Controlled Substance Medication Agreement

(1) **Richmond Spine Interventions and Pain Center** (referred to as RSIP) is dedicated to treating your chronic pain condition. This agreement is to protect both your access to controlled substances and how we prescribe medications for you. To receive or continue care, you and a family member over the age of 21 years need to be familiar with all parts of this agreement. After you and your family member have read each paragraph, please initial in the spaces provided. By initialing, you and your family member acknowledge that you understand and agree to abide by the corresponding statements.

Patient Initial	Cosigner Initial

(2) If you or your family member does not understand that statement, please ask your RSIP provider to explain that statement. You will be asked to sign this document periodically throughout your care while you are being prescribed gabapentinoids/opioids or other controlled substances.

Patient Initial	Cosigner Initial

(3) My RSIP provider is prescribing opioid medication, sometimes called narcotic analgesics, or other controlled substances for my condition. This decision was made because my condition is serious and/or other treatments have not helped my pain.

Patient Initial	Cosigner Initial

Controlled Substance Risk Awareness

(4) I am aware that the use of such medication(s) has certain risks associated with it, including, but not limited to: sleepiness/drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, abnormally slow breathing rate, delay of reflexes or reaction time, addiction/physical dependence, tolerance to analgesia, and possibly incomplete pain relief.

Patient Initial	Cosigner Initial

(5) The long-term use of substances like opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial due to uncertainties about their long-term benefits. Additionally, there is a risk of developing dependence or addiction, or of relapse in individuals with a history of addiction. The extent of this risk remains unclear.

Patient Initial	Cosigner Initial

(6) Because these medications have the potential for abuse or diversion, strict accountability is necessary with prolonged use. For this reason, I, the patient, agree to the following policies as a requirement from all RSIP providers to initially prescribe or continue prescribing controlled substances for treating my chronic pain.

Patient Initial	Cosigner Initial

(7) I understand that taking opioid pain medications in conjunction with benzodiazepines, i.e., Xanax, Valium, Lorazepam, or other hypnotics, for example, Ambien, etc, will result in a higher risk of overdose. I will inform RSIP providers and other prescribing physicians if I am taking a combination of these medications or if another provider is suggesting prescribing them to me. I understand that these therapies can be much safer if my providers communicate, and I will do my best to facilitate that.

Patient Initial	Cosigner Initial

Long-Term Treatment Plan Regimen/Detoxification

(8) I understand that the goals of my pain management treatment plan include time-contingent use of narcotics and may include a weaning regimen to reduce dosage and dependence on these medications. While physical dependence is to be expected after long-term use of narcotics, signs of addiction (psychological dependence) will be interpreted as a need for weaning or detoxification.

Patient Initial	Cosigner Initial

Pharmacy

(9) **All** controlled substances must be obtained from the **same** pharmacy, whenever possible. The pharmacy must be legal and licensed in the United States. If you need to change the pharmacy on file, it is your responsibility to inform our office.

Patient Initial	Cosigner Initial

(10) I understand that it is my responsibility to call my pharmacy before a refill is due and inquire if the medication is in stock. It is my responsibility if the medication is not in stock, I will call different pharmacies and find a pharmacy that has my medication in stock. I will then inform the RSIP staff that my typical pharmacy is out of stock and give the staff the name of the alternate pharmacy and their contact information.

Patient Initial	Cosigner Initial

Prescription Accountability, Medication Refills & Access

(11) I will not alter or change my controlled substance prescription. I will take my medication as prescribed, and I will not run out of my narcotic or controlled substance before the designated time the prescription is to be renewed. I understand that altering or abusing my prescription medication can result in harm or death to others or myself. I will not hoard my medications, and I will let my RSIP provider know if I have leftover medications from my last prescription at each visit.

Patient Initial	Cosigner Initial

Keeping the Medications in a Secure Place

(12) I will not share, sell, or otherwise permit others access to my prescribed medications. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. I will take the highest possible degree of care with my medication and written prescription. They will not be left where others might see or otherwise have access to them. **I will store my medications and prescriptions in a locked cabinet/safe. Only my family member who has signed this agreement below and I will have access to the cabinet, key, and/or combination.**

Patient Initial	Cosigner Initial

Lost or Stolen Medications

(13) I understand that narcotic prescriptions are **my responsibility**. If anything happens to my written or filled prescription **(stolen, thrown away, flushed, washed in the laundry, consumed by a pet, etc.)** I am responsible. **NO** prescriptions will be written until the designated time the prescription is to be renewed. I understand that any of the above-mentioned events may result in dismissal from RSIP and referral to another pain management practice.

Patient Initial	Cosigner Initial

(14) I will not hold any member of Richmond Spine Interventions and Pain Center liable for problems caused by the discontinuance of a controlled substance. If any prescriptions are lost or stolen, they **WILL NOT BE REPLACED**.

Patient Initial	Cosigner Initial

Medication Refill Policy

(15) I understand that I should discuss any concerns about my medications at the time of my visit with the provider. I understand that Richmond Spine will not change my medications or the dosage over the telephone or email, or patient portal, except for true emergencies. This is a safety measure in my treatment plan.

Patient Initial	Cosigner Initial

(16) I understand that my medication refills will only be fulfilled at the time of my visit, except for true emergencies.

Patient Initial	Cosigner Initial

Controlled Substance Prescriptions for More Than One Month

Patient Initial	Cosigner Initial

(17) If I am prescribed more than one month of my medication at the time of my visit. Before your second prescription/refill is due, I will contact the pharmacy first to see if I have multiple prescriptions or refills on file. I am aware that prescription bottles for controlled substances may not show refills on the bottles.

Patient Initial	Cosigner Initial

(18) I understand that providers are unable to write refills on opioid medications. I understand that refills may not be displayed on medication bottles. I understand that my provider may decide to see me in two to three months for a follow-up appointment. In order to do this, my provider will send more than one opioid prescription for the same medication to be filled at the appropriate time. I understand that it is my responsibility to contact my pharmacy before the second or third prescription is to be filled to inquire about the following:

1. Does the pharmacy have the prescription?
2. Does the pharmacy have the prescription in stock? If they do not have the prescription in stock please see paragraph 10.

Patient Initial	Cosigner Initial

(19) I understand that I am responsible for calling my pharmacy before leaving the office after my appointment to verify the following:

1. That the pharmacy has received my prescription(s)
2. I will ask my pharmacy to **"run my prescription"** while they are on the phone with me, and if required, ask the pharmacy to send RSIP a request for prior authorization via fax, before leaving the RSIP office.

Fridays, Weekends, and After-hours Refills

Patient Initial	Cosigner Initial

(20) Refills will not be made during evenings, weekends, or holidays. An office visit is required for a refill of controlled substance medications. Refills will not be made if I **"run out early"**. I understand that I am responsible for taking the medication as prescribed and for keeping track of the amount remaining. Refills will not be made as an **"emergency",** such as on a Friday afternoon, because I have suddenly realized **"I will run out tomorrow"**. I will call at least 2 weeks ahead for an appointment if I need assistance with a controlled substance medication. **I will not call the office for a medication refill on Fridays, on any weekdays after 5 pm, or on weekends.**

Treatment from Multiple Sources

Patient Initial	Cosigner Initial

(21) I understand that receiving treatment from multiple providers for my pain syndrome, which I am being treated for at RSIP, will increase my risk of medication interactions and complications. These treatments may include pain medications, spinal injections, spinal cord stimulation, or kyphoplasty for vertebral compression fractures.

Patient Initial	Cosigner Initial

(22) I will do my very best to carry a copy of my RSIP agreement card and present it to all of my providers involved in my care. I will also present this card to any providers who are planning on performing elective procedures and will ask them to contact RSIP to coordinate my care plans. These procedures may include spinal injections, surgery, or kyphoplasty for vertebral compression fractures.

Patient Initial	Cosigner Initial

(23) I understand that failure to follow the above-outlined procedures may result in my dismissal from care from RSIP.

When to Notify My RSIP Provider

Patient Initial	Cosigner Initial

(24) I will notify my RSIP provider immediately if I develop serious side effects, become pregnant, am prescribed any new medications, or have been diagnosed with any new medical conditions (including any psychiatric diagnosis). If it is necessary for me to visit the emergency room due to pain, I will present the emergency department staff with my RSIP agreement card and notify my RSIP provider as soon as possible after the visit. I further understand that if I have a problem with or a question about the above statement, I may make an appointment to discuss this with my RSIP provider and receive clarification before a crisis or problem arises.

Urine or Blood Screenings

Patient Initial	Cosigner Initial

(25) I will not use, purchase, or otherwise obtain illegal drugs. I agree to submit to random urine and/or blood screens to detect the use of non-prescribed medications at any time. I understand that I must submit a urine and/or blood sample to the lab at the time specified by the provider. This time might range from 24 to 72 hours from the time the order was written.

Patient Initial	Cosigner Initial

(26) I understand that the presence of illegal or legal substances such as marijuana, alcohol, cocaine, or the presence of any other controlled substances, which are not prescribed by my RSIP provider, in my urine or blood may lead to dismissal from the practice.

Patient Initial	Cosigner Initial

(27) I understand that inconsistent urine or blood test results may be grounds for dismissal from the practice. An example of an inconsistent urine test result is: the presence of a medication not prescribed by the provider, an illegal substance present in the urine or blood, and/or the absence of the prescribed medication from the urine. I may be asked to do a repeat urine or blood test if there is an inconsistency in my original blood or urine test. I further understand that all urine and blood tests will be at my own expense.

Pill Counts

Patient Initial	Cosigner Initial

(28) I may be asked to bring in medications at any time for a pill/patch count. I will be called and must report to the RSIP office within 24 hours with the correct number of pills/patches. Failure to present to the RSIP office could be grounds for discharge from the practice.

Activity Limitations/Restrictions

Patient Initial	Cosigner Initial

(29) I will not participate in any activity that may be dangerous to me or someone else if I feel drowsy or if I am not thinking clearly. Such activities include, but are not limited to: using heavy equipment, operating a motor vehicle, or being responsible for another individual who is unable to care for him or herself. I am aware that even if I do not notice it, my reflexes and reaction time might still be delayed.

Patient Initial	Cosigner Initial

(30) I understand that **state law prohibits driving and operating dangerous equipment while taking any sedating medication, even if you do not feel sedated.**

Right to Privacy

Patient Initial	Cosigner Initial

(31) I waive my right to privacy so that the prescriber can contact **ANY** healthcare provider, pharmacist, and/or legal authority to obtain/provide information about my care. The prescriber has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my healthcare to maintain accountability. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, from obtained medications at several pharmacies, all confidentiality is waived, and the authorities may be given full access to my records.

(32) I understand that I must add my family member listed on this agreement on my HIPAA form so that my care team may communicate with them.

Addiction Risk and Drug History Disclosure

Patient Initial	Cosigner Initial

(33) I am aware that addiction is defined as the use of a medicine even if it causes harm, cravings for another drug, and/or feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is present. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has a family/personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge. I understand that a history of conviction in a drug-related crime will be a cause of dismissal from the practice, and a conviction in any other crimes may result in dismissal from the practice as well.

Patient Initial	Cosigner Initial

(34) I will inform my RSIP provider if I or a member of my immediate family or any member of my household is using any illegal substances, cocaine, or marijuana, or is misusing and/or abusing prescription drugs.

Patient Initial	Cosigner Initial

(35) I understand that physical dependence is a normal, expected result of using these medications for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some agents, I will experience a withdrawal syndrome. This means that I may experience all or any of the following: runny nose, yawning, large pupils, goosebumps, abdominal pain/cramping, diarrhea, irritability, body aches, or flu-like symptoms. I am aware that opioid withdrawal is uncomfortable but not life-threatening in most cases.

Analgesia Tolerance

Patient Initial	Cosigner Initial

(36) I am aware that tolerance to analgesia means that I may require more medication to get the same amount of pain relief. I am aware that tolerance to analgesia is not a major problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing my dose of the medication may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids/gabapentinoids may cause my prescriber to choose another form of treatment.

Effects of Chronic Opioids (Reproductive Health)

Patient Initial	Cosigner Initial

(37) **[MALE]** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and/or sexual performance. I understand that my prescriber may check my blood to see if my testosterone level is normal.

Patient Initial	Cosigner Initial

(38) **[FEMALE]** If I plan to become pregnant or believe that I have become pregnant while taking my pain medication, I will immediately call my obstetrician and my RSIP provider to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon gabapentinoids and opioids. I am aware that the use of opioids is not generally associated with the risk of birth defects, however, birth defects can occur whether or not the mother is taking medicine, and there is always the possibility that my child will have a birth defect while I am taking an opioid.

Policy Adherence

Patient Initial	Cosigner Initial

(39) It is understood that failure to adhere to these policies may result in termination of therapy of controlled substances, cessation of prescribing by RSIP providers, or referral for further specialty assessment. I give my consent to allow Richmond Spine Interventions and Pain Center to make inquiries and to receive reports from the Prescription Monitoring Program.

My signature in this form specifies that I have read and understand the above agreement. I was given adequate time to review and sign this agreement. The risks and potential benefits of these therapies have been explained to me, and my questions were answered. I affirm that I have the full right and power to sign and will be bound by this agreement and that I have read, understand, and accept all of these terms.

Printed Name: _____Date of Birth: _____/_____/_____

Patient Signature: _____Date: _____/_____/_____

Family Member's Full Name: _____

Family Member's Signature: _____Date: _____/_____/_____

Family Member's Contact Information: _____

(Family members must be at least 21 years of age. If you do not have any family members, please speak with your provider.)*