MedNOW Clinics, Inc

Patient Agreement for Using Opioid Pain Medication and Other Controlled Substances

This agreement between_____ (Patient) and MedNOW Clinics, Inc. concerns the use of opioid analgesics (narcotic pain-killers) and other habit-forming medications (collectively "Controlled Substances").

The medication I am prescribed will not completely eliminate my symptoms, but is expected to reduce symptoms enough that I may become more functional and improve my quality of life. Since my provider is prescribing this medication for me to help manage my symptoms, I agree to the following conditions: (Please initial each statement)

1. _____ I understand that Controlled Substances are strong medications and I have been informed of the risks and side effects involved with taking them.

2. _____ I understand that Controlled Substances could cause physical dependence. If I suddenly stop or decrease the medication; I could have withdrawal symptoms (for narcotic medications, these include flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweating, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable but not a life-threatening condition. I understand that if I am pregnant or become pregnant while taking these Controlled Substances, my child may be physically dependent on the medication, and withdrawal can be life-threatening for a baby.

3. _____ Overdose on narcotic and benzodiazepine medications may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers, benzodiazepines or other Controlled Substances. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

4. _____ If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

5. _____ I understand it is my responsibility to inform my provider of any and all side effects I have from this medication.

6. _____ I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without prior approval by the prescribing provider. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication, and may be reasons for my provider to discontinue prescribing this medicine to me.

7. _____ I agree that the Controlled Substances will be prescribed only by my provider,_____, or his/her designated representative, and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind altering medication prescribed by any other provider without first discussing it with the above-named provider and having approval. I give permission for the provider to verify that I am not seeing other providers for Controlled Substances or going to other pharmacies by accessing my information on the Colorado Prescription Drug Monitoring Program.

8. _____ I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication

will not be replaced.

9. _____ I agree not to sell, lend, or in any way give medication to any other person.

10. _____ I agree not to drink alcohol or take mood altering drugs while I am taking the Controlled Substance(s). I agree to submit a urine specimen at any time that my provider requests, and give my permission for it to be tested for alcohol and drugs.

11. _____ I agree that I will attend all required follow-up visits with the provider to monitor my medication(s), and I understand that failure to do so will result in discontinuation of this treatment. I agree to make my follow-up appointments at least 7 days in advance. I also agree to participate in other chronic pain treatment modalities recommended by my provider.

12. _____ I understand that there is a risk that addiction could occur. This means that I might become psychologically dependent on the medication(s), using it to change my mood or get high, or be unable to discontinue my use of it. People with a past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

13. _____ Refills of Controlled Substance medication will be made only during regular office hours, in person, once each month during a scheduled office visit. Refills will not be made at night, on holidays, or weekends, and will not be made if you "run out early" or as an "emergency," without being seen. You are responsible for taking the medication(s) at the dose prescribed and for keeping track of the amount remaining.

14._____ Our providers use the Prescription Drug Monitoring Program (PDMP) website, which gives a list of a patient's medications that have been filled at pharmacies by all providers in the state of Colorado and some other states. Our Providers use this website to help us determine all the locations from which a patient is getting controlled substances.

15. _____ It is our clinic policy that all patients using Controlled Substances will have a professional evaluation by a specialist (neurosurgery, orthopedics, spine specialist, pain management specialist psychiatry, etc.) to determine the appropriate long-term use of the Controlled Substance(s). This evaluation must be completed by the specialist within thirty (30) days of starting the Controlled Substance(s) or first being prescribed it by our providers, and a consultation note must be received from the specialist for our files within that sixty (60) day period. It is also our clinic policy that our providers will follow the recommendations of the specialist. Failure of the patient to obtain a consultation from the specialist will result in our providers no longer being able to prescribe the Controlled Substance medication(s).

I have read the above, asked questions and understand the agreement. If I violate the agreement, I know that the provider may discontinue this form of treatment and that the provider may also terminate our provider-patient relationship.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date