Northwest Pain Management Associates (NWPMA)
A Division of Proliance Surgeons

Pain Treatment Agreement

Patient Name_____ **Date of Birth**_____ Date: _____
(Print)

Effective pain management requires that the patient and the clinician work together. This agreement is designed to make sure that you understand the rules we will use in your care. If you do not understand any part of this agreement, please discuss it again with your clinician. It is important that you understand that if you do not fulfill your obligations with your care, we will be less effective in helping you and may have to stop treating you altogether.

Please read and follow this agreement carefully.

1. The scope of our practice is pain management. You understand the providers at NWPM are not primary care providers. You understand you must maintain regular visits with your primary care provider for general medical issues.

The name of my primary care provider is _____.

2. Only **one** pharmacy may be routinely used. Pharmacy Name: _____ Phone Number: _____

3. You must treat the office staff, (including billing office and any providers and their staff we may refer you to) as colleagues alongside providers with courtesy and respect at all times. We have a zero-tolerance policy regarding what is perceived by the staff to be rude or harassing comments or actions. This includes repeated phone calls requesting or demanding medications or early appointments, and the use of profanity. Patients who exhibit this behavior in the opinion of our providers or office staff will be terminated from the practice immediately. X_____

4. You agree to take your medication exactly as prescribed; if you wish to change the way you are taking your medicine, please discuss it with your doctor or physician assistant **beforehand**. X_____

5. You agree to take only your own medication and not to take someone else's medication even if you think it is the same medicine, and not to share your medication with anyone else. X_____

6. You agree that we will be the only clinicians prescribing chronic pain medication for you. You must let us know about all other medicines prescribed to you by other physicians or any other health care providers, including dentists. It is permissible for you to receive pain medication from another clinician for acute pain events. You must notify us within 5 days of any such events. X_____

7. If you receive opioid therapy you will be required to obtain naloxone to be used in case of overdose. X_____

8. You agree not to use alcohol, or take any street or recreational drugs, including marijuana, (medical or recreational), during the course of treatment. You understand that the danger of mixing opioids with alcohol, marijuana or other unauthorized substances can be severe, up to and including death. X _____

9. You agree not operate motorized equipment or drive a vehicle if feeling impaired, after beginning pain medication, or after a change (such as a dose increase) until the effects are known. You understand that although you are receiving therapeutic, prescribed medication and are monitored regularly for adverse effects, this does not prevent you from being charged with driving under the influence. X _____

10. You are responsible for informing your employer about your use of pain medications, if so required. X_____

11. You agree to advise us of any over-the-counter drugs, vitamin supplements, and herbal remedies, as well as any other prescribed medications you are taking. X _____

12. You give consent for on-demand, unscheduled toxicology screening (drug testing), and pill counts. Aberrant findings may result in immediate cessation of prescribing of controlled substances. X_____

13. You agree to participate in psychiatric or psychological assessments, including assessment for substance abuse or addiction, sleep studies, community safety evaluations and pharmacogenetic testing for medications, if requested. X_____

14. Usually we will prescribe enough medication to last until your next visit or next scheduled medication refill date. **We will not provide** additional refills before that. Prescription refills require minimum 72-hours notice. This will allow the appropriateness of the refill to be reviewed by the provider, and prevent any discomfort you may have by running out of your medication. You must call during regular office hours for your refills as refills are not given after hours, on weekends, or on holidays. Refills requests **cannot** be left with the answering service. Refills for medications are not given on an emergency basis. X_____

15. Prescriptions are like money, you must protect these medications from theft or diversion. If you lose your medications or the written prescriptions, they will not be replaced. You will have to wait until your scheduled refill date. X_____

16. Take along only the amount of medicine you need when leaving home; there is less risk of losing all your medications. Carry medications only in a properly labeled pharmacy prescription container. Your name and the name of the medication must be on the container. Carrying pills in a non-pharmacy container may result in felony charges if discovered by law enforcement. X_____

17. You must have a current (valid) WA state I.D. in order for us to prescribe. X_____

18. You are required to provide (and update as needed) a phone number where we may reliably reach you. You are required to return our call within 24 hours. X_____

19. I understand that there are conditions that warrant the discontinuation of pain medication therapy, including but not limited to: interference with functional goals, lack of effectiveness, concerns of misuse of medications, inability to appropriately steward medications, and failure to follow instructions. X _____.

20. I agree to allow the Physician/Provider at NWPMA to discuss my medical care with any of my other medical care providers or physicians. X _____.

21. I understand that there are circumstances that obligate NWPMA to notify proper authorities if they suspect that illegal activity has occurred in regards to medication. I waive any applicable right or privilege of confidentiality with respect to the prescribing of my pain medication, and I authorize the prescribing physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency or authority in the misuse, sale, or other diversion of my pain medications. X_____

22. Your provider assumes no responsibility for any criminal charges that may be filed against you as a result of your pain medication use. You acknowledge that you understand this and hold the providers and staff at NWPMA harmless for any damages or criminal charges that occur as a result of using pain medications. X_____

23. I understand any and all co-pays and co-insurances are due at the time of service. (NO CHECKS are accepted) X_____

24. If a phone consult is scheduled you will be charged $50.00-$150.00 based on duration of the call. This charge is not covered by your insurance company, and will be your sole responsibility. X_____

25. You are required to attend all follow-up appointments scheduled for you. You are required to check in a minimum of **10 minutes prior** to your appointment for processing paperwork. If you must reschedule the appointment, you must call 24 hours in advance or you will be charged a no show fee of **$75** (1st time) and **$150** thereafter. The same fees will apply to tardiness. Continuing to be late or having multiple no shows will result in termination of care. X_____

26. You are responsible for any balance due and agree to pay all balances owing within 90 days from the date of service and pay a $10.25 service fee per month. X_____

By signing below, you agree to abide by these rules and agree that you have read and understood them. In addition, you are indicating your questions have been answered to your satisfaction. If you feel you will not be able to honor the commitments made in this agreement, you may notify us now or at any time. If you are not able to live by the agreement we may need to terminate your care with us. If this occurs, we will attempt to notify you either in person or at your last known address or phone number.

Signing below, you are giving us permission to share this agreement with other physicians and pharmacies.

Patient/Legally Authorized Representative Signature_____ **Date**_____

The concurrent use of high dose opioids, as defined by the CDC, and benzodiazepines (such as Valium, Ativan, temazepam, lorazepam, Xanax and clonazepam) is in direct violation of the state and federal guidelines. In an effort to comply with these guidelines we may need to taper you off your opioids. X_____

Potential Side Effects of Opiates

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness, and tolerance. Also you should know about the possible dangers associated with the use of opioids while operating heavy equipment or driving.

Side effects of opioids include (but are not limited to) the following:

X_____Confusion or other change in thinking abilities
X_____Nausea
X_____Constipation
X_____Vomiting
X_____Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
X_____Sleepiness or drowsiness
X_____Breathing too slowly - overdose can stop your breathing and lead to death
X_____Aggravation of depression
X_____Dry mouth
X_____Decreased sex drive and lower testosterone levels in men
X_____Itching

These side effects may be made worse if you mix opioids with other drugs including alcohol and benzodiazepines, such as Valium, Ativan, temazepam, lorazepam, Xanax and clonazepam.

Risks Include: (but are not limited to) the following:

Physical dependence: This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following: runny nose, diarrhea, sweating, rapid heart rate, difficulty sleeping for several days, abdominal cramping, goose bumps and nervousness. X_____

Psychological dependence: This means it is possible that stopping the drug will cause you to miss or crave it. X_____

Tolerance: This means you may need more and more drug to get the same effect. X_____

Addiction: Some patients may develop addiction problems based on genetic and or social factors. If taking prescription pain medicine triggers the disease of addiction in you, the consequences may be severe. These consequences include loss of personal relationships, impaired job performance up to and including the loss of employment, legal consequences leading to arrest and imprisonment, and health consequences leading to disability or death. X_____

Problems with pregnancy: If you're pregnant or contemplating pregnancy, discuss this with your doctor or his associates. X_____

Recommendations to manage your medications:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness, and any side effects you may be having.

- Take along only the amount of medicine you need when leaving home; there is less risk of losing all your medications. Carry medications only in a pharmacy labeled prescription container, including your name and the name of the medication.

Do you use tobacco or nicotine? ___Yes ___No Type: _____ Number of Years: _____

If not currently, how much in the past? _____ Year quit: _____

If you are not currently or have never been a tobacco or nicotine user, you may stop here. However, you must still sign at the bottom of this page.

If you answered "Yes" to the first question, please read the following information and initial at each X_____.

"Of all the modifiable behaviors, smoking remains the largest cause of preventable death in the world. Aside from the obvious medical conditions associated with smoking, such as lung cancer, chronic bronchitis, and coronary heart disease, smoking is also the root cause of many musculoskeletal disorders. **Smoking alters the processing of pain and its perception so that <u>smokers perceive increased pain</u>**. Experimental studies indicate that nicotine has analgesic properties with initial use, but epidemiological evidence shows that smoking is a risk factor for chronic pain. Prolonged exposure to nicotine induces acetylcholine receptor desensitization and tolerance to nicotine-induced antinociception." X___

"In addition to changes in pain processing, smoking can induce structural changes in other systems **that will predispose patients to painful musculoskeletal conditions. Smoking may accelerate degenerative processes and make the body more vulnerable to injury. Smoking also increases the risk for lumbar disc disease and impairs bone and wound healing**." X___

"The association between smoking and low back pain is likely due to nicotine-associated disk degeneration, in which the toxic activity of nicotine increases the degradation of collagen and disc matrix proteins. In addition, vascular damage and vasoconstriction results in a decreased supply of blood and oxygen to the discs." X___

Tobacco or nicotine use may escalate your pain and/or decrease the effectiveness of pain medication. Tobacco or nicotine use is a modifiable risk factor for chronic pain. We may follow the lead of other pain clinics and discontinue prescribing for tobacco or nicotine users. X___

If you are interested, we have complete copies of the article available upon request.

(Excerpts from "Smoking and Back Pain: Adding Insult to Injury." By Brian F. White, DO, FAAPMR. The Pain Practitioner Volume 26 Number 6 (2016) Pages 21-23.)

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described in pain treatment agreement.

Patient Name_____
(Print)

Patient Signature_____ Date_____