MMC
SPINE, JOINT AND PAIN CENTER

Patient Medication and Treatment Agreement

I, _____ am seeking healthcare services for the treatment of my pain condition from Dr. Brenna Green I understand that treating my condition will require a plan/program involving drug therapy for pain management. There are numerous state and federal laws and regulations regarding the use of prescription drugs and specifically controlled substances such as opioids. The purpose of this agreement is to help this healthcare practice and myself comply with these laws and regulations. I also understand that it will provide me with information about my treatment plan and help me understand my pain, as well as the medications I am prescribed.

GOALS OF THERAPY

I understand that my provider and I will work together to find the most appropriate treatment for my pain. I understand the goals of treatment are not to completely eliminate pain but to manage my pain in order to improve my ability to function. Opioid therapy is only ONE part of my overall pain management plan.

I understand that opioid treatment for pain is used to reduce pain and to improve what I am able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve my ability to do daily activities. This may include exercise, use of non-narcotic analgesics, injections, physical therapy, psychological counseling or other therapies or treatment.

I understand that pain represents a complex problem that benefits from injections, medications, physical therapy, psychotherapy, and behavioral medicine strategies. I recognize that my active participation in the management of my pain is extremely important to improve my functioning and ability to cope. I agree to actively participate in all aspects of treatment.

I agree to see other health care providers for evaluation and treatment of related and other medical conditions if determined necessary.

PATIENT DISCLOSURE OF CURRENT MEDICATIONS AND HISTORY OF SUBSTANCE ABUSE

CURRENT MEDICATIONS

I will inform my physician of all medications I am taking, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone. I understand that the use of alcohol and opioid medications is contraindicated.

History of Substance Abuse

I understand that patients with a history of substance abuse, including alcohol abuse, are at high risk of relapse from certain medications. Patients with a strong family history of substance abuse are also at high risk for potential addiction.

I have notified Brenna Green, DO of any personal or family history of substance abuse, including alcohol abuse.

DEFINITION OF A SINGLE PROVIDER AND PHARMACY

I agree to use _____ Pharmacy, located at _____, telephone number _____, for filling prescriptions for all of my pain medicine.

I will not seek opioid medications from another physician. Regular follow-up care is required and only my provider will prescribe these medications for me at scheduled appointments.

INFORMED CONSENT ON THE RISK OF USING OPIOIDS

I have been counseled by my physician regarding potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. I am also aware that there are possible dangers associated with the use of opioids while operating heavy equipment or driving.

POSSIBLE SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly — overdose can stop your breathing and lead to death
- Nausea
- Sleepiness or drowsiness
- Vomiting
- Constipation
- Aggravation of depression
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF I MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

DEFINITION OF ADDICTION, TOLERANCE, AND PHYSICAL DEPENDENCE

Physical dependence and/or tolerance can occur with the use of opioid medications.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations to one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

SELF-REPORT ON PAIN, SIDE EFFECTS, AND FUNCTION AT FOLLOW-UP VISITS

I will communicate fully to my physician to the best of my ability, at the initial and all follow-up visits, my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

ESTABLISHMENT OF REGULAR FOLLOW-UP CARE VISITS AND MEDICATION REFILLS

Changes in my prescriptions, including dose adjustments, refills, and new medication, will be made only during scheduled office visits and not over the phone or during unscheduled visits. Telephone calls regarding opioid medication should be limited to reports of significant side effects necessitating decreasing or stopping the medication.

I understand that to safely manage patients on opioids requires routine follow up appointments. The frequency of appointments are determined based on an administered risk assessment tool, schedule class of opioid and other confounding factors. Routine follow-up appointments could be as soon as 2 weeks but no longer than two months. Follow up appointments beyond 2 months are determined at the discretion of the provider. I understand that if I have not been seen in 60 days, no medication can be refilled until I come to the office for an appointment or at the discretion of the provider. Procedure appointments are not counted as appointments, as the providers do not have time to discuss medications with you at that time. Lost or stolen medication will be replaced at the discretion of the physician.

REQUIREMENT FOR PRESCRIPTION RENEWAL DURING OFFICE HOURS

Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends. Medication refills and change requests can be made by telephone Monday through Thursday, 9 am until 4 pm. Refill requests after 12pm will not be reviewed until the next business day. Refills should not be requested earlier than 3 days prior to scheduled refill. There will be no refills given on Fridays.

CONSENT TO RANDOM URINE DRUG SCREEN TESTS OR PILL/PATCH/STICK COUNTS

It is the policy of Brenna Green, DO (and most other pain centers) to occasionally perform urine drug tests and/or blood tests on those patients taking potent medications. There may, or may not be a cost to the patient for these tests, but we will be unable to prescribe medications to any patient who refuses such a test no matter what the reason.

Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that I will take the highest possible degree of care with my medication and prescription. They should not be left where others might see or otherwise have access to them. Original containers of medications should be brought in to each office visit. I will bring all unused pain medicine to every office visit.

At any point, you may be contacted to bring all unused pain medicine to the office within 24 hours. If you cannot make it to the office within 24 hours, you may stop by any pharmacy and have that pharmacist count the amount of remaining medicine. We will then contact that pharmacy for verification.

DEFINITION OF TERMS OF NONCOMPLIANCE AND TERMINATION OF TREATMENT

Evidence of misuse/abuse of opioids will result in tapering and discontinuation. Specific examples of misuse/abuse include injecting or snorting oral formulations; selling, giving away, or borrowing opioids; and frequent dosage escalations despite warnings.

Other unacceptable activities include prescription forgery; obtaining drugs from nonmedical sources; concurrent use of alcohol or illicit substances; repeatedly seeking prescriptions from other clinicians or emergency room departments; deterioration in functioning at work, in the family, or socially; and repeated resistance to changes in therapy despite clear evidence of physical or psychological side effects.

I understand my obligation to meet these requirements and that any of the following situations may result in my provider choosing to stop writing opioid prescriptions for me. Withdrawal from the medications will be coordinated by the provider and may require specialist referrals.

- **No Improvement/Loss of Effect Demonstrated**

  If my physician feels that opioids are not effective for my pain or that my functional activity is not improved, opioid medications may be changed or withdrawn.

  _____ **(Initial)**

- **Refusal/Failure to Comply With Screenings or Other Recommended Treatment**

  If I fail to comply with other parts of recommended treatment (i.e. physical therapy, behavioral management plan, etc.) _____ **(Initial)**

- Missed Appointments

  If I consistently fail to keep my scheduled appointments. Patients will be allowed no more than 2 missed appointments or cancellations less than 24 hours prior to their visit. _____ **(Initial)**

- **Lost or Stolen Prescriptions**

  I understand that I am receiving medications that are at high risk of being stolen. I am responsible for protecting these medications. Brenna Green, DO cannot replace medications or prescriptions that are lost or stolen, including prescriptions lost in the mail. I also understand that if my medications are stolen, I must file a report with local law enforcement agencies. _____ **(Initial)**

- **Use of Illegal Controlled Substances**

  I will not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. Use of illicit substances may result in termination of the doctor/patient relationship.

  I am not involved in the use, sale, possession, diversion, or transport of illegally obtained controlled substances (narcotics and/or illegal drugs). _____ **(Initial)**

- **Sharing, Selling or Trading**

  I understand that selling, trading, or giving a medication to another person, including a family member, is illegal. _____ **(Initial)**

- **Misconduct to Staff**

  I agree not to use abusive language, or threaten the doctor or his staff. I am not to call the office multiple times during the same day. This is considered harassment and may effect the doctor's decision to continue to provide me controlled substances or continue to retain me as a patient. _____ **(Initial)**

- **Return of unused medication**

  I agree to bring in all unused medication for disposal purposes, if my prescription is being changed. All unused medicine is counted and disposed of in front of the patient. _____ **(Initial)**

- **Prescriptions from other providers**

  I agree to contact my physician if I do obtain a prescription for narcotics from another provider. _____ **(Initial)**

- **Alcohol and Opioids**

  I understand that I am not to consume any alcohol while I am being prescribed opioid medications.
  _____ **(Initial)**

PATIENT WAIVER OF PRIVACY

I allow my doctor to receive information from any health care provider or pharmacist in this state about use or possible misuse or abuse of alcohol or other drugs. This permission shall expire only upon my written cancellation of this agreement.

I understand that Dr, Brenna Green fully cooperates with all law enforcement agencies. If I violate this contract, Brenna Green, DO and staff MUST consider that I may be abusing or selling medications. They will report such activities suspicious of selling medications to the appropriate law enforcement agencies for further investigation. In such instances, doctor—patient confidentiality does not prevent doctors from providing pertinent information to law enforcement agencies.

REPORTING DRUG SEEKING BEHAVIOR TO LAW ENFORCEMENT AGENCIES

If I seek opioid medications from another provider or Brenna Green, DO has good reason to believe that I am trying to obtain or have obtained the same or a similar medication from another prescriber, I agree and understand that Dr. Brenna Green is required under Tenn. Code Ann. § 53-11-309 to report such drug seeking behavior to law enforcement agencies.

To the fullest extent permitted by applicable law, I hereby release and absolutely discharge Brenna Green, DO and her employer and any affiliated entities, and each of their heirs, agents, directors, officers, employees, assigns, representatives and insurers (collectively, the "Releasees"), from any and all claims, demands, damages, debts, liabilities, accounts, reckonings, obligations, costs, expenses, liens, attorneys' fees, actions and causes of action of every kind and nature whatsoever, whether known or unknown, that are directly or indirectly related to or arising out of any actions that the Releasees take to report drug seeking behavior to law enforcement agencies and/or cooperate with law enforcement agencies relating to such reporting ("Released Matters"). I hereby covenant and agree not to commence, prosecute or cause to be commenced or prosecuted against the Releasees any action or proceeding based upon or arising out of or related to any of the Released Matters. This Section shall survive the termination or expiration of this agreement.

Requirement That Patients with a History of Substance Abuse Must Continue Recovery Programs

If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:

- 12-step program and securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment
- Other: _____

MISCELLANEOUS CLAUSES

- Pregnancy

I understand the potential harm of opioid medication to unborn children and agree to notify Brenna Green, DO if I am or become pregnant in the future. _____ (Initial)

I _____ have read this document, understand it, and have had all questions answered satisfactorily. I agree to the use of opioids to help control my pain, and I understand that my treatment with opioids will be carried out in accordance with the conditions stated above.

Physician signature_____ Date _____

Patient signature_____ Date _____

Witness signature_____ Date _____