COMPREHENSIVE
PAIN MANAGEMENT
SPECIALISTS

THERAPEUTIC AGREEMENT FOR CONTROLLED SUBSTANCES

Both the Comprehensive Pain Management Specialists' staff (the physicians and staff) and I (the patient), have a common treatment goal: To improve my ability to function and/or work. In consideration of that goal, I am being treated with potent medications. Examples are narcotics, tranquilizers and /or barbiturates. These medications are considered controlled substance medications and their use is closely controlled and monitored by local, state and federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse. Also, these medications have the potential for various side effects and these will be explained prior to treatment.

I have been fully informed by the Comprehensive Pain Management Specialists physicians and staff about psychological dependence (addiction) to controlled substance. If this happens, I will follow my physician's guidance and participate in any treatment programs prescribed, which may include detoxification, psychological counseling and medical treatment. Failure to comply will result in discharge from Comprehensive Pain Management Specialists.

I agree to abide by the following conditions:

A baseline drug screen completed on the first clinic visit.

I agree that all controlled substance medications and prescriptions shall be prescribed only by my CPMS physician.

Obtaining other controlled medications from any other individual or physician without informing CPMS will be considered a violation of this agreement. The only exception is medications prescribed while I am admitted in a hospital.

I will take the medications as directed, no more and no less. If I use up my medication sooner than prescribed, I understand that they will not be replaced before my next scheduled visit and my pain may return.

I know that some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. I also understand that as a result of other treatment modalities or the natural course of my disease process, my pain may decrease. Therefore, my medication doses will have to be adjusted (increase/decrease) as deemed appropriate by my physician. I will not adjust the medication by myself.

I understand that if I stop taking the medications abruptly, this may be dangerous and lead to withdrawal symptoms. If the medication needs to be discontinued, I will do so gradually and only under medical supervision.

I am responsible for my controlled substance medications. If the medications or prescriptions are lost, misplaced, stolen or disappear for any reason, we are not responsible for the replacement. You must contact the CPMS staff regarding the loss of your prescription or medication immediately.

I am responsible for keeping track of the amount of medications remaining and obtaining refills at my scheduled office visits.

I agree to help myself by trying to change my behavior towards a healthier lifestyle including; stop smoking, using only legal drugs that have been prescribed to me by my physician, use of alcohol only in moderation as permitted by my physician, diet and weight control, adherence to physical therapy (as directed) and exercise. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

THERAPEUTIC AGREEMENT FOR CONTROLLED SUBSTANCES (cont.)

I understand that if I violate any of the above conditions, my controlled substance prescriptions and /or treatment at CPMS may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described above, the incident will be reported to my primary physician, local medical facilities and in some cases, other authorities. The CPMS also retains the right, at its sole discretion, to release a person from the program at any time.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

PRIVACY STATEMENT

I have been given a copy of/ had the ability to view the Privacy Statement for Comprehensive Pain Management Specialists. I am aware of my Rights and Responsibilities and the times my Protected Health Information can be shared.
I am aware I can file a complaint with the Privacy Officer.

Contact Person:
Coriandra Sammon, Privacy Officer
Comprehensive Pain Management Specialists
2215 E. Waterloo Rd, Suite 313
Akron, OH 44312

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of/ had the ability to view the Patient Rights and Responsibilities for Comprehensive Pain Management Specialists. I am aware of my Rights and Responsibilities. If you believe that at any time one or more of the statements have not been met with your care, please ask to speak to a Supervisor or the Director.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

COMPREHENSIVE
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PAIN MANAGEMENT AGREEMENT

I, _____ commit to Comprehensive Pain Management Specialists' program. My initials below indicate my understanding of the following:

- I agree to a drug screen at any time at the discretion of my physician. If found positive for illegal substances positive for medications not prescribed to me or negative for medications that have been prescribed, my physician has the right to immediately dismiss me from the program.
- I will show up for all recommended treatments and tests.
- I will comply with my program's attendance policy and may be dismissed from the program if I have multiple missed appointments.
- I understand on my first consult that I may not be given a prescription.
- I will follow the physician's prescription regime as prescribed. If receiving medications, I will adhere to the Agreement for Controlled Substances.
- I understand that I may be asked to bring in my medications for a pill count at any time during the program.
- I understand that it is my responsibility to make sure that I do not run out of my medications prior to my next scheduled office visit.
- I understand that narcotics cannot be prescribed over the phone. I understand that no prescriptions will be issued if I have not had an office visit within the last 30 days.
- I will notify the Comprehensive Pain Management Specialists' staff of any changes to my insurance, demographics (address, phone number).
- I understand that for each no showed appointment, a fee will be assessed as stated in the Financial Policy.
- If I am unable to make my appointment, I will call and cancel within 24 hours.
- I understand that if I arrive late for my appointment, I may be asked to reschedule.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

PAIN MANAGEMENT AGREEMENT (cont.)

Pharmacy Name: _____

The phone number to my pharmacy is: _____

· I agree that I will use ONLY the pharmacy I have listed above for my prescriptions. _____ (Int)

· Should I have to change pharmacies, I will contact the office to update my records. _____ (Int)

I have read the above patient commitment agreement with Comprehensive Pain Management Specialists' program. I have initialed all statements. I understand that if I fail to comply with the commitments that I am making, I will be discharged from the Comprehensive Pain Management Specialists' program.

Name: _____ Date of Birth: _____

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

I decline a copy of the pain agreement. _____ (Int)