CAHABA PAIN AND SPINE CARE

Controlled Medication Agreement

I, _____, understand that I have pain that has not been adequately controlled with other medications and that my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain completely.

I understand that opiates and opioid pain medications, including my medication, have abuse potential. I understand that addiction is a risk of taking these types of medication. I will do my best to communicate with my physician any patterns of medication misuse or overtaking.

I understand that my pain medication, when overtaken, can cause multiple medical problems including death.

I understand that taking my medication consistently in certain doses and for certain time periods may result in physical dependence, whereby stopping the medication abruptly may result in withdrawal symptoms. I understand that opiate withdrawal by itself is not potentially fatal and that my doctor may prescribe me medications for instances of opiate withdrawal at his/her discretion.

I will communicate my concerns regarding my medication with my doctor, and I will not increase my medication unless instructed by my doctor.

I will take the medication only as prescribed. I will not take any sedatives or other pain medications without the prior approval of my doctor.

I understand that the medication will be prescribed only by **Dr. Thoma and/or Dr. Martin** or designated provider at **Cahaba Pain and Spine Care.** Prescriptions will be provided only during regularly scheduled appointments or during designated pick-up times as arranged on a case by case basis at the discretion of my doctor. Refills of controlled medications will never be provided by telephone.

I will not seek any medications for pain other than those prescribed by my doctor. “Medications for pain” includes prescriptions from other doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs. If my condition changes acutely, such as an injury or complication, and another physician prescribes me pain medication, I must consult with **Cahaba Pain and Spine Care** before filling the prescription. Failure to do so may result in my doctor stopping my pain medication.

Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working day’s notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.

I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor’s discretion, I agree to undergo drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.

I understand that my doctor may elect to call me in for a “pill count” with at least 48 hours advanced notice and that I must bring all of my prescribed medications in their appropriate prescription bottles or boxes. I understand that failure to show up for this appointment or having an inappropriate medication count may result in my doctor stopping my medication.

I understand that my doctor may elect to call me in for a urine drug test at any time with at least 48 hours advanced notice if I am receiving controlled medications. I understand that failure to show up for this appointment or having an inappropriate urine drug test result may result in my doctor stopping my medication.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. I understand that my doctor may not replace lost or stolen prescriptions.

I understand that my doctor may require specialist evaluation of my treatment, and I agree to make appointments when my physician refers me.

In addition to the above agreements, I accept the right of my doctor’s medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than my doctor.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well-being or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that am no longer a good candidate to continue the medication.

I agree to fill my prescriptions only at the pharmacy I list below. If I change pharmacies, I will contact my doctor’s office and provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time.

Pharmacy name _____Pharmacy telephone _____

Pharmacy address_____

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

Patient Signature _____ _____/_____/_____