BKC PAIN SPECIALISTS

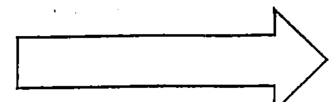
CONTROLLED SUBSTANCES AGREEMENT

This controlled substances agreement is entered between ______________________________ and physician(s) of BKC Pain Specialists LLC. The purpose of this agreement is to establish rules for the use of opioid medications, their safe use, and their appropriate prescribing.

Violation of this agreement may result in increased office visits, testing, or possible dismissal from the practice.

1. Alternative therapies and medications have been explained and offered to me. I agree that starting opioid/controlled substance therapy is a trial, just one component of treatment.
2. I will receive prescriptions for opioid medication only from BKC Pain Specialists LLC.
3. I will take my pain medications as prescribed and will not alter how I take these medications unless instructed by my physician.
4. I will attend *all scheduled appointments* with the provider to which I have been referred.
5. I will allow my physician to contact those that are listed on my HIPAA form and other treating practitioners for their assistance in managing my conditions and the use of my medications.
6. I will not share, sell or otherwise permit others to have access to these medications.
7. I will avoid alcohol and illegal drugs while I'm taking narcotics.
8. I will submit to random pill counts and urine, saliva, or blood tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day emergency only period.
    a. I agree to text messages or phone calls for pill counts. It is my responsibility to provide an accurate phone number by which text messages may be sent or phone calls may be made. Failure to update my phone number could result in a failed pill count, which may result in a lapse in treatment. I agree to respond to the text message, even if I am unable to come in for my pill count, by phone or text.
9. It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following: allergic reactions; overdose (which could result in harm or even death); slowing of breathing rate; slowing of reflexes or reaction time; sleepiness, drowsiness, dizziness, and/or confusion; impaired judgment and inability to operate machines or drive motor vehicles; nausea, vomiting, and/or constipation; itching; physical dependence or tolerance to the pain relieving properties of the medication (meaning that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and

SEE OTHER SIDE



cramping, diarrhea, irritability, body aches, and a flu-like feeling. These can be very uncomfortable but are generally not life-threatening.); addiction; failure to provide pain relief; changes in sexual function (generally caused by reduced testosterone levels); changes in hormone levels.

10. I understand that my provider will not replace lost or stolen medications. It is my responsibility to keep my medication safe, and failure to do so will result in my being without medication until my refill is due. This may cause withdrawal symptoms as described above.
11. I understand that my pain specialist has partnered with a third party company, SafeRx Solutions, that specializes in Compliance Medicine. This company is authorized to bill my insurance company for office visits, even though these office visits are at the same date/time/location as my pain specialist office visit. This company will access my drug screens, prescription history, and any medical record pertinent to making sure I am compliant with my medications. The staff of SafeRx Solutions may contact all the prescribers of my controlled substances even if they aren't affiliated with BKC. I understand that failure to comply with the recommendations set forth by SafeRx Solutions may result in a lapse in my treatment by my pain specialist or dismissal from the clinic.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINES.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN A LAPSE IN TREATMENT OR PERMANENT DISCONTINUATION OF OPIOID PRESCRIPTIONS, AND POSSIBLE DISMISSAL FROM THIS CLINIC.

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Patient Signature　　　　Printed Name　　　　Date

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Physician Signature　　　　Printed Name　　　　Date

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Witness Signature　　　　Printed Name　　　　Date