Northwest Anesthesiology and Pain Services, PA

MEDICATION/OPIOID CONTRACT

I, _____, agree to the following guidelines as part of my treatment for chronic pain management with a provider from Northwest Anesthesiology & Pain Services, PA.

1. I understand the following:
   - If I have a chronic pain problem, it may require the prescription of opioid pain medications to increase my quality of life by increasing my function and reducing my pain perception. I understand that Opioid medications can also be prescribe for short term, temporary, acute pain problems. The risks, side effects, and benefits of the medication have been discussed with me in detail in the event that chronic opioid therapy is indicated. I agree to the policies set forth by Northwest Anesthesiology and Pain Services, PA in accordance to the federal and state guidelines, for toxicology monitoring and diagnostic testing needed to evaluate the risks associated with opioid treatment.
   - I understand that the use of the opioids in pain Management is an acceptable practice, however, there is a potential for habit formation and in some instances, may result in addiction.
   - If I am treated with opioid medications, I agree to take the medications only as prescribed and I will not accept a prescription for an opioid based, controlled substance, from another physician, without approval from my provider. An exception to this would be in an emergency situation, where I will notify the ER Providers of my opioid contract with Northwest Anesthesiology and Pain Services, PA.
   - I will use only one pharmacy to obtain prescribed controlled substances and any changes to this must be discussed with the provider prior to any changes. The pharmacy will be in the greater Houston area associated with the office I am being treated in, not out of the state of Texas. I give full consent for my provider and pharmacist to exchange information in writing or verbally. I also understand that changing pharmacies regularly is considered by the state and federal government as high risk behavior for drug aberrancy and I will comply with the office policy for toxicology testing when doing so.
   - I understand that opioids are not effective long term, as single therapy, due to tolerance and dependency. An opioid prescription will be used in conjuncture a with multi-modal therapeutic plan, focused on interventional treatment options. If I am prescribed opioids, the goal is to continuously reduce and/or taper me off of them. To do so, I will meet the provider regularly to assess my progress. If the provider does not feel that opioid therapy is medically indicated, then they are not obligated to continue prescribing them.
   - I am responsible for any lost, misplaced, stolen or miscounted medications from the pharmacy. The provider will not replace my medications or refill my medications early in the event that this occurs. I will not share my medications with anyone. A stolen medication will require a police report to be made and a notification to my provider within 48 hours of loss.
   - I agree to participate in any medical or psychological assessments recommended by my provider for assessment for dependency, aberrancy or worsening of any comorbid conditions. I also understand that I will comply with Urine Drug Testing Policies of the office, including random sampling and pill counts. Failure to show up at the allocated time for random testing would forfeit my next prescription.
   - The use of illegal drugs can lead to immediate discontinuation of opioid therapy and possible dismissal from the practice, at the discretion of the provider and practice. If toxicology testing is indicated, I will follow the protocols for toxicology testing as well as be responsible for any financial costs, if not covered by my insurance.
   - I understand that at every visit I will bring all prescription medications with me in their original containers on every appointment even if the bottle is empty. Failure may result in the rescheduling of my appointment.
   - Failure to comply with ordered procedures or test may result in the discontinuation of medications.

2. I understand that my provider may stop prescribing the medications listed if:
   - I do not show any improvement in pain or my activity has not improved.
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.
   - The clinic finds that I have broken any part of this agreement.
   - My toxicology diagnostic testing reveals I am not following the recommended dosages for my prescriptions or the testing reveals I have used illegal or street drugs.
   - *My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from receiving further care from this clinic following guidelines set forth by the Texas State Medical Boards.*

SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOD MEDICATIONS:
There are potential adverse effects that may occur while working and taking opioid medications. These adverse effects could potentially be dangerous and cause safety risks. These include delayed reaction time, impaired judgement, drowsiness, and physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time.

ADVERSE EFFECTS OF MIXING OPIOID MEDICATIONS:
These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol.

- Feeling of Anxiety
- Confusion
- Dizziness /Drowsiness
- Impaired Judgment
- Slowed or Difficult Breathing
- Constipation
- Nausea
- Vomiting
- Slow Heart Rate
- Excessive Sweating
- Difficulty Urinating
- Physical/Psych Dependence

RISKS:
Abruptly stopping the medication may lead to withdrawal symptoms. The symptoms below may be harmful if you are being treated with other co-morbid conditions. Please do not stop medications without the supervision of your provider.

- Runny Nose
- Diarrhea
- Sweating
- Rapid Heart Rate
- Difficulty Sleeping for Several Days
- Abdominal Cramps
- Shakes and Chills
- Nervousness

I have read the above **MEDICATION/OPIOID CONTRACT.** By signing this contract, I affirm that I have read, understand and accept all terms of the contract and appropriate opportunity was allocated to me by the provider to answer any and all questions that I may have prior to prescribing opioids.

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Northwest Anesthesiology and Pain Services, PA
7010 Champions Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321