Phoenician Medical Center
"Quality Healthcare Begins with Us"

PHOENICIAN PAIN CENTER

OPIOID CONTRACT

INITIAL ALL PLEASE!

NAME: _____ **DOB:** _____

_____ I understand the purpose of this agreement is to prevent misunderstandings about certain medications I will be taking for pain management. This is to help me and my doctor comply with the law regarding controlled medications.

_____ I understand that if I break this agreement, _____ will stop prescribing me medications.

_____ I will not use any illegal substances, i will not increase or decrease the dosage, if I feel that adjustments in the medication dosage is required, i agree to contact the prescribing provider.

_____ I agree and understand that i can not test positive for the if prescribed schedule II opioid medications (even with a valid medical marijuana card).

_____ I will not share my medications with anyone nor will i take another person's medications.

_____ I will not receive any controlled medications from any other doctors, and I will only use one pharmacy (as listed below.)

_____ I understand that it is my responsibility to safeguard my medication. Should they be lost, stolen or destroyed or if they are used up early, the medication(s) will not be filled under any circumstances.

_____ I agree not to sell, lend or in any way give my medication to another person.

_____ I agree not to drink alcohol or other mood altering drugs while i am taking controlled medications.

_____ I understand that there may be risks associated with the use of controlled medication, including risk of death, respiratory depression, bowel and bladder dysfunction, sexual dysfunction, change of appetite with possible weight gain or loss, change of coordination (which may interfere with driving, operating machinery and fine motor movement) and others.

_____ Additionally, the continuous use of controlled medication may result in dependence, addiction, changes in personality, and sleep changes. I also understand that I will not mix alcohol with controlled medication and I will report any changes in my mental state as well as possible side effects.

_____ I agree to submit to urine drug screens or blood work testing on an as needed basis to monitor for medication complications and compliance with recommended treatment.

_____ I understand that sudden stopping of pain medication can lead to rebound pain, withdrawal symptoms, seizures and other symptoms. I have been informed not to stop any controlled medication suddenly unless decided jointly by myself and my pain doctor.

_____ I agree to allow my physician to review any of my past medical or psychological records.

_____ I agree that when i have any contact with the phoenix neurological & pain institute staff members: medical assistants, physicians, assistants, phone schedulers, etc. That i will not be rude, aggressive, swear or be disruptive.

_____ I agree that I will not use benzodiazepines while undergoing chronic pain management with opioids at phoenix neurological and pain institute. I understand the use of benzodiazepines and other substances/medications is violation of this contract.

_____ I understand that failure to comply with my provider's treatment plan is a violation of this contract and I may be discharged due to non-compliance. This includes no showing and canceling appointments and surgeries, failure to complete physical therapy and/or sleep studies, etc.

_____ I have read and understand the above information. I agree and understand that non-compliance with the above will result in formal discharge with notification to my physician and other treating physicians.

PATIENT SIGNATURE: _____ **DATE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

PHARMACY NAME: _____ **PHONE #:** _____