AINSWORTH INSTITUTE OF PAIN MANAGEMENT

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OPIOID TREATMENT & PAIN MANAGEMENT AGREEMENT

This is an agreement between _____ (the patient) and Corey W. Hunter, MD (the doctor) concerning the Use of narcotic pain-killers & opioid analgesics for the treatment of my chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life. The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management and the conditions under which you will be expected to comply with. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals and is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

1. I understand that opioid analgesics are strong medications for pain relief and I. have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting diarrhea, aches, sweating, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable but not a life- threatening condition.

3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life- threatening for a baby.

4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

5. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

6. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

7. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication, and may be reasons for the doctor to discontinue prescribing to me.

8. I agree that the opioids will be prescribed by only one doctor, and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind altering medication prescribed by any other physician without first discussing it with the above named

doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replacedI agree not to sell, lend, or in any way give my medication to any other person.

10. I will not attempt to obtain and/or use any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor or person.

11. I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic medication.

12. I will not use any illegal controlled substances, including marijua na, cocaine, etc.

13. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and drugs to determine my compliance with my program of pain control medicine..

14. I agree that I will attend all required follow-up visits with the doctor to monitor this medication, I will bring all unused pain medicine to every office visit, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

15. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

16. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

17. I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines. In this case, my doctor may choose to taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not deemed to be viable option, you will be provided with a 30 (thirty) day supply of your medications to maintain while your care is transferred to a new physician. Also, a drug-dependence treatment program may be recommended. All information regarding your care will be transferred to your new treating physician upon request.

18. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any

possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

19. To the best of my knowledge, I am not pregnant at this time. I understand these medications are considered dangerous to a fetus. I will do everything possible to avoid getting pregnant while taking these medications unless otherwise approved by my doctor

I have read the above and understand the agreement. All of my questions and concerns regarding treatment have been adequately answered. I agree to follow these guidelines that have been fully explained to me.If I violate the agreement, I know that the doctor may discontinue this form of treatment. A copy of this document has been given to me.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date