Tulsa Bone & Joint Associates

OPIOID THERAPY PATIENT-PROVIDER AGREEMENT AND INFORMED CONSENT

PATIENT FULL NAME	AGE	DATE OF BIRTH	MEDICAL RECORD NUMBER
M ☐ F ☐			

OPIOID THERAPY PATIENT-PROVIDER AGREEMENT

Thank you for choosing Tulsa Bone & Joint Associates (TJBA) to receive your healthcare. The goal of our physicians' and staff is to provide you with the highest quality and safest possible care. This often requires a team approach, to control your pain and improve your **level of** function. Narcotics (opioids) and other controlled substances (any prescribed medication with abuse / dependence potential) may be one of the options used in your care.

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Our goal is to provide you with the best quality treatment of your pain. To accomplish this goal, your physician will customize your treatment plan to best fit your healthcare needs. During the course of your treatment, your physician may or may not prescribe medications. When opioids and other controlled medications are the best option, it is important to review and follow the policies to ensure your safety and our continued ability to treat you in the most effective way possible.

Please read this carefully, as these policies will be enforced. You are required to initial next to each section and sign this agreement stating your understanding and compliance before receiving any pain medication.

_____ The pain management treatment plan has been discussed, understood, and agreed to by you and your physician. You understand the reason why this prescription is necessary. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to you, and you still desire to receive medications for the treatment of your chronic pain. You are expected to comply with and actively participate in all aspects of the plan and the responsible use of medications.

_____ **You understand that opioids and other controlled medications are prescribed to increase your function, activity level and quality of life.** These medications may reduce your pain but may not provide complete relief. Your treatment plan will be evaluated, at least, every three months. You agree to fully communicate your pain level, functional ability and any side effects of the medication to the best of your ability. If these aspects do not improve with these medications, the risks of the medication outweigh the benefits or there is the potential of negative effects related to another medical condition or medication, your provider may reduce or eliminate the medications from your treatment plan.

_____You agree to inform your physician of all medications you are taking, including herbal remedies, since Opioid medications can interact with over-the-counter medications and other prescribed medications. This is especially true of cough syrup that contains alcohol, codeine or hydrocodone.

_____ To ensure your safety, **it is your obligation and responsibility to take medications exactly as prescribed by your physician** (dose and frequency). You understand that these medications can lead to physical dependence and/or addiction, and can be associated with other risks including, but not limited to, decreased effectiveness, physical and psychological dependence, confusion, itching, difficulty urinating, constipation, allergic reactions, decreased sex drive, drowsiness, nausea or vomiting, trouble driving and/or operating machinery. Taking more opioids than prescribed or mixing sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

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_____You agree **to only take pain medications prescribed by the providers of this medical practice**. Do not take any pain medication given to you by another person or provider (health, dental, clinic or emergency department) or increase your dosage without authorization from this physician. You understand that taking more medication than prescribed or taking pain medication from another source may lead to **overdose** that could result in slowed or stopped breathing, brain injury from lack of oxygen, coma, or death.

_____ You understand that there is an increased risk of overdose associated with the use of opioids in combination with medications used to treat anxiety disorders, panic attacks, insomnia or seizures (benzodiazepines), alcohol and other central nervous system depressants. If you are prescribed these medications by another provider at any time during your pain management treatment, you must inform your physician immediately. You must also inform all other treating healthcare providers of the medications being prescribed as a part of your pain management treatment plan.

_____ You understand this clinic has a policy of limiting dosing to 100mg of Morphine or equivalent maximum doses as outlined in the CDC Opioid Treatment Guidelines and state law. You agree to comply with such policies and dosing limitations.

_____ You understand Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings**. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history.**

_____ You understand your medications are required to last for the duration prescribed. You must safeguard and protect your prescription medications, including keeping them in a safe place and away from children. It is recommended you keep them in a locked safe or cabinet. You must not share, sell or otherwise permit others to have access to these medications. **If you fail to meet this prescribed timeline, your medication is lost, misplaced, destroyed or stolen, early prescription refills will not be permitted.** This physician reserves the right to choose to taper or discontinue medications that are lost or stolen.

_____ If you intend to stop taking your medications, have a negative reaction, or fail to submit your prescription refill request according to the policies below, you must discuss this discontinuation of medications with your physician prior to doing so. Sudden discontinuation of medications may result in withdrawal, including nausea, shakiness, sweating, rapid heart rate, diarrhea, high blood pressure, pain or severe nervousness. If your physician discontinues your medications as a part of the treatment plan, non-compliance or dismissal from the practice, you will be provided with a weaning or tapering dose to avoid negative withdrawal effects.

_____ All prescriptions will be obtained at **one pharmacy**, when possible. Should the need to change pharmacies arise, you must inform our office immediately. The prescribing physician and staff have permission to discuss history, diagnostic and treatment details with dispensing pharmacists or other professionals who provide you healthcare. Please list your pharmacy below:

_____

(Print name of Pharmacy Address, and Telephone Number)

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The following are policies related to prescription refills:

_____You understand you **must be assessed by our providers prior to every opioid prescription refill**.

_____You must inform your provider of any changes in other prescribed or OTC medications, medical condition, surgical history, relevant family history, social history, or civil actions related to the use of opioids, narcotics, alcohol, or illegal substances.

_____ **Patients will only be seen during office hours:**

Monday-Thursday 8:30 am to 4:00 pm. No exceptions will be made. At TBJA, many of our physicians are surgeons – office hours are further restricted and opioid prescription appointments will *not* be available every day. Please talk to the medical assistant for the physician you are seeing.

_____You agree to comply with medication compliance monitoring as needed. These include, but are not limited to:

_____ **Random pill counts** may be required and must be responded to within the given timeframe. If you live outside of a 60-mile radius from our office, your local pharmacy or doctor's office may perform the requested pill count and report the results to our office. Counts that are inconsistent or failure to comply with a requested pill count will be viewed as noncompliance and may result in dismissal from this practice.

_____ **Random urine or blood drug screenings** may be requested. Presence of illegal, unauthorized substances, absence of prescribed medications or other abnormal results may result in discontinuation of your controlled medications.

Failure or refusal to provide a sample for drug testing will be viewed as non-compliance and may result in dismissal from our practice.

_____ This clinic and/or physician retains the right to discuss your treatment with law enforcement officials during any official investigation.

_____ You agree to read the package inserts and prescription bottle labels for any prescribed medications. You will discuss any questions or concerns regarding contraindications or reactions with your physician. You will inform this clinic, immediately, if you have a reaction or are allergic to any prescribed medication.

_____ You may be asked to obtain a Narcan or opioid "overdose kit", available from local pharmacies without a prescription. Failure to comply may result in discontinuation of medication.

_____ You must keep your scheduled appointments. If you are unable to make it to an appointment, you must provide 24-hour notice to cancel. **If you fail to appear or give the required notice of cancellation, your medications may not be refilled**. If you fail to appear for more than 2 appointments, you may be dismissed from our practice.

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_____ **You understand that if anytime, your provider has reason to believe that you are not in compliance with the terms of this agreement or your treatment plan, the provider may terminate this agreement and medications with a proper weaning dose. If you wish to terminate this agreement, please contact our office for guidance.**

_____ **(Female Patients Only)** To the best of your knowledge, you are NOT pregnant. You agree to use appropriate contraceptive during your course of treatment. **If you do become pregnant or suspect pregnancy, you will notify your physician IMMEDIATELY.** You understand there are potential *risks associated with pregnancy and chronic opioid therapy. You or your unborn child may experience significant or serious side effects related to the medications you are prescribed.

_____ ***(Patients Currently Pregnant)** **The short-term use of opioids for acute pain can be safe when prescribed by your physician. Long-term use of opioids can be harmful for your unborn baby. There is also a risk of neonatal abstinence syndrome with use of opioids that can require in-hospital treatment of the baby after birth. You should discuss alternatives to opioids for pain control, but non-steroidal anti-inflammatory drugs should not be used in the third trimester of pregnancy.**

ALL PATIENTS:

Your health care team is dedicated to your safety and the control of your pain, and we must have your cooperation to achieve these goals. The agreement is designed to ensure your safety and to help us and you comply with the standards of good medical care, as well as, state and federal laws related to chronic opioid therapy. Please sign below.

The above agreement has been explained to me by my physician or clinic staff. Any and all questions or concerns have been answered or addressed to my satisfaction. I agree to comply with the terms contained herein and understand that failure to do so may result in termination of the physician/patient relationship and/or termination from this medical practice.

PATIENT'S SIGNATURE	DATE	TIME
WITNESS	DATE	TIME
SIGNATURE OF PERSON AUTHORIZED TO SIGN FOR PATIENT	REASON PATIENT UNABLE TO SIGN	
RELATIONSHIP TO PATIENT		

TRANSLATION – This is to certify that the above Consent has been provided in printed format or read to the patient (or representative) in his/her native language. The patient (or representative) understood and agreed and was asked to sign the English version (legally valid document) and was shown where to indicate a Consent.

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	INTERPRETER/WITNESS SIGNATURE