NORTH FULTON RHEUMATOLOGY
LONG-TERM CONTROLLED SUBSTANCE THERAPY FOR CHRONIC PAIN

Long-Term use of such substances as opioids (narcotic analgesics), benzodiazepines, tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they may provide long-term benefit. There is also risk of an addition disorder developing or relapse of such occurring.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

PLEASE READ AND INITIAL NUMBER 1 THRU 22

_____**1.** As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if not managed properly. Your health & safety are very important to us and we need **your help** to make sure your treatment follows our guidelines. **The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professional and family members or law enforcement, if necessary, for the purpose of maintaining accountability.**

_____2. I understand that taking my medications earlier than prescribed or allowing it to be lost, stolen or destroyed in any way places me at risk for withdrawal which is medically risky and potentially fatal. I acknowledge that I cannot hold North Fulton Rheumatology or any of the staff liable should I go into withdrawal. **If I take my medication earlier than prescribed or allow it to be lost, stolen, or destroyed in any way, I take full responsibility. I will not attempt to obtain more medication earlier than prescribed.** NO EARLY **REFILLS WILL BE GIVEN on narcotic pain medications.**

_____3. I agree to **never** share my medications with others, nor will I sell or exchange my medication for any reason.

_____4. I agree to inform this office of any new medications or medical conditions, or if I experience any adverse side effects or dosage problems with any of my prescribed medications.

_____5. I agree that if I receive any narcotic prescriptions from this practice, I am not allowed to receive the same type of medications from another physician without expressed consent or consultation from Dr. Lopez-Armstrong.

_____6. I agree to use one pharmacy **ONLY** for my pain-related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify North Fulton Rheumatology of all pertinent information pertaining to additional pharmacies, mail order, or other sources.

_____7. I understand the refills on narcotic pain medications **require a scheduled office visit**. I also understand that narcotic pain medications (requiring a written prescription) will not be called into my pharmacy, mailed or faxed, nor will they be increased over the phone. If I am having problems with my medication, I understand that Dr. Lopez-Armstrong or other licensed healthcare professional associated with North Fulton Rheumatology, will require seeing me in the office. I agree to keep all scheduled appointments.

_____8. I understand that **NO MEDICATION WILL BE GIVEN IF I CANCEL OR FAIL TO SHOW FOR MY APPOINTMENT**. I agree to be prompt to my appointment and understand that **if I am more than 15 minutes late, I may be required to reschedule at the next available appointment.**

_____9. I understand that North Fulton Rheumatology requires 24-48 hrs. notice on prescription refills, if I fail to follow this requirement, I may run out of my medication, in which case I will be liable for any consequences that this may cause. I understand that I must contact North Fulton Rheumatology during regular business hours.

_____10. **I agree to have available all of my prescribed medications at the time of my office visit.** I understand that pill counts may be necessary for controlled substances.

_____11. I understand that I should not drive or operate machinery while I am taking medications that may cause drowsiness or impair cognitive function and that doing so may result in **DUI or serious injury/death to myself or others** for which I will be solely responsible.

_____12. I understand that I should avoid the use of alcohol (**Beer, Wine, Whiskey, or Mixed Drinks of any kind.**) Ingestion of alcohol with narcotic pain medications may cause a sedative effect resulting in decreased consciousness (inability to awaken from sleep) **or even death.**

_____13. I understand that since the drugs may be hazardous or lethal to a person who is not tolerant to the effects, especially a child, you must keep them out of reach to such persons.

_____14. I understand that my therapy and North Fulton Rheumatology may legally require monthly office visits (every 30 days) so that we can properly evaluate my progress and/or if needed, appropriately adjust narcotic pain medications. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

____15. I understand that abusive behavior or harassment toward any member of the staff of North Fulton Rheumatology for Pain Management will not be tolerated. Harassment includes, but is not limited to more than two (2) phone calls to the office in one business day regarding the request for pain medication(s).

____16. **I will not show up to North Fulton Rheumatology unannounced or without an appointment seeking medication refills.**

____17. I understand that forged or falsified prescriptions will result in the immediate dismissal from North Fulton Rheumatology and notification to the proper authorities.

____18. **I understand that the Dr. Lopez-Armstrong or other licensed healthcare professional associated with North Fulton Rheumatology reserves the right to REQUEST A URINE DRUG SCREEN OR SERUM TOXICOLOGY SCREEN AT ANY TIME! If I fail to submit the specimen within the requested time frame, I understand that this is grounds for immediate dismissal from the practice.** If my screen tests positive for illicit substances or negative for medications prescribed to me, I understand that these drugs should not be stopped abruptly, as an abstinence syndrome (withdrawal) will likely occur and that if I am dismissed from this practice, I will have **30 days** to find a new physician.

____19. I understand that the use of opioids to treat chronic pain may result in an increase in pain or lack of effect and that the proper course of action at that time may be to reduce or eliminate opioids as part of the pain treatment regimen.

____20. **Males Only:** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

____21. **Females Only**: If I plan to become pregnant or believe that I have become pregnant while taking this pain medication, I will immediately call my obstetric doctor and North Fulton Rheumatology to inform them. I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

____22. I understand that if I do not follow this medication agreement, that I may be dismissed from North Fulton Rheumatology.

____23. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

Physician's Signature

Patient's Signature (or legal representative)

Printed Name of Physician

(Patient's Name Printed)

Pharmacy Name and location

Pharmacy Phone Number

I have verbally asked this patient or had such message interpreted to the patient that the patient read or had read each of the above statements and have agreed to such.

Signature of Health Care Personnel

Date