



ELPIS PAIN MANAGEMENT CENTER
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Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines that the patient will be taking for pain management. This is to help both patient and provider comply with the law regarding controlled medications.

This agreement relates to my use of controlled substance for chronic pain prescribed by a physician at the **Elpis Pain Management Center, O'Fallon, Missouri**. I have been informed and understand the policies regarding the use of controlled substance that are followed by the staff at the **Elpis Pain Management Center, O'Fallon, Missouri**. I understand that I will be provided controlled substance while actively participating in this program only if I adhere to the following conditions:

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to completely eliminate pain but to control my pain in order to improve my ability to function. **Chronic Opioid therapy is only ONE part of my overall pain management plan.**
2. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. **I agree to take the medication at the DOSE and FREQUENCY prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the discontinuation of opioid therapy.**
3. I will attend all appointments, treatments, and consultations as requested by my provider. **I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.**
4. I will tell my provider about the level and description of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
5. **I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, injections or interventional procedures and other pain control strategies.** I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition. If treatment for my condition is available, I agree I will not refuse the treatment just so the opioids will be continued. **I understand that I have the right to refuse any procedure, but that does not mean that my provider must continue to prescribe narcotic or opioid medications.**
6. **The risks and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgment and affect reflexes and motor skills. I will not participate in activities that would endanger me or others while using these medications. This includes but is not limited to using heavy equipment, motor vehicles, power tools, working at heights and caring for someone who may be dependent on me.**

- 7. I agree I will not use any illegal controlled substances, including Marijuana, Cocaine, Heroin, Methamphetamine etc. I agree I will not use any prescription medications obtained illegally, or obtain them from friends or relatives.**
- 8. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.**
- 9. I agree I will not share, sell or trade my medication with anyone.**
- 10. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event.**
- 11. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing the Elpis Pain Management Center, O'Fallon, Missouri Physician / Staff first. I agree to have my opioid prescriptions filled ONLY at a pharmacy listed on page five (5) of this agreement.**
- 12. I agree that I will not be given any medication refills on my first visit to the Elpis Pain Management Center, O'Fallon, Missouri. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 4 pm, on weekends, holidays, or through the emergency room. Medications will not be mailed or refilled without being seen at monthly pain clinic appointments (if patient is receiving opioids from the pain clinic).**
- 13. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.**
- 14. I agree to bring in all unused pain medicine when requested.**
- 15. I will submit urine for drug testing if requested by my provider to determine compliance with my program of pain control. Urine toxicology results will be submitted to your insurance company for payment, but you may be liable for these charges if your insurance company does not pay.**
- 16. I authorize the Elpis Pain Management Center, O'Fallon, Missouri to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.** If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
- 17. I will accept generic brands of my prescription medications.**
- 18. I understand that I may become tolerant to, addicted to or have complications from the opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will permit referral to addiction specialists.**
- 19. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician.**
- 20. I understand that if I violate any of the above conditions, my provider may choose to stop providing opioids prescribed for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals.**

21. I understand that if I or a family member are verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the institution.

22. **FOR MALES:** I am aware that **chronic opioid use can be associated with lower testosterone levels**, and may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may choose to check my testosterone levels at intervals to see if it is normal.

23. **FOR FEMALES:**

If I plan to become **pregnant** or believe that I may become pregnant while taking these medications, I will report immediately to an obstetric doctor and this office and inform others. **I am aware that many pain medications and opioids / narcotics taken during pregnancy may cause birth defects and will cause the baby to be physically dependent on medications at birth.**

If I plan to **breastfeed**, I will report immediately to an obstetric doctor and this office and inform others. **I am aware that many pain medications and opioids / narcotics taken while breastfeeding may cause problems with multiple organ systems of the baby's body and can cause disability or life threatening illnesses or death etc. That can also cause the baby to be physically dependent on medications.**

24. I understand that suddenly stopping pain medicines and using certain medications such as Nubain (nalbuphine), Talwin (pentazocine) and Stadol (Butorphanol) may reverse the actions of my opioid / narcotic medications and can cause withdrawal symptoms including but not limited to: **Flu like Symptoms, Rapid Heart Rate, High Blood Pressure, Heart attack, Irritability, Large pupils, Stroke, Seizures, Abdominal pain / cramping, Diarrhea, Permanent damage, Disability or Death**

25. I understand that **Elpis Pain Management Center, O'Fallon, Missouri** will share medical information with my referring physician and primary care physician.

26. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects especially a child, you must keep them out of reach of such people.

27. **ANY** violation of this agreement may result in termination of the physician- patient relationship.

No Show and Return Check Policy

Elpis Pain Management Center, O'Fallon, MO will institute a "No Show Policy" and "Return Check Policy" effective 07/01/2013.

As a patient in our Practice, it will be your responsibility to keep scheduled appointments.

Our office requires notification of cancellation at least 24 hours prior to the appointment or earlier if possible.

Your appointment will be cancelled if you are more than 15 minutes late from your scheduled appointment.

Please contact our office to cancel and reschedule an appointment.

A No Show charge will be applied to your account if advance notice is not given. The charge will range from \$25.00 to \$100.00 depending on the type of appointment missed.

There is a charge of \$35.00 for any returned check, plus the amount of the check. We will not accept a check from anyone who has had a returned check with us in the past.

Pain Management Agreement

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Medication Refill information:

1. Advance notice of 5-7 business days is required for all **non-opioids** refills of the prescriptions
2. Requests for scheduled refills for **non-opioids** must be telephoned to the pharmacy only during regular office hours Monday - Thursday (8:30 am – 5:00 pm). Refills will not be made at night, on holidays, or on weekends.
3. **Most controlled substance cannot be telephoned in to the pharmacy.**
4. I will be given a (30) thirty days supply each month.
5. All hard copies of the opioids prescriptions must be hand delivered to the pharmacy by myself

- I agree to have my opioid prescriptions filled only at _____

- **This agreement will supersede all other agreements**
- I have received a copy of “No Show Policy” from Elpis Pain Management Center, O’Fallon, Missouri.
- **By signing below I indicate that I understand AND agree to ALL the terms of the above agreement. I have received a Copy of this for my own records.**

Patient _____ Signature

Witness _____ Signature

Provider _____ Signature

Date _____