<u>CHRONIC PAIN TREATMENT AGREEMENT</u>
ADVANCED PAIN CENTERS, S.C.

Patient Name: ____ Date of Birth _______________

I understand that the purpose of this Agreement is to prevent misunderstandings about my treatment and certain medications I may be taking for pain management. This is to help both me and my physician to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes to treat me based on this Agreement.

I understand that if I break any term of this Agreement, my physician will stop prescribing these pain-control medications and has the right to discharge me from the Pain Center. In this case, my physician shall provide me with a thirty (30) day prescription of medicine (provided medication was not already obtained from another provider(s)), and any scheduled appointments or emergency appointments during that thirty (30) day period.

I understand that my physician will discuss the use of narcotic medications with me, including the issues of appropriate realistic goals, side effects and specific issues of developing tolerance dependence, habitation, addiction and withdrawal problems due to these medications and that I will have a chance to ask questions regarding the use of narcotic/opioid medications.

I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication(s) are helping to relieve the pain. I understand that I must maintain regularly scheduled appointments to follow up with my provider regarding my medications and that it is my responsibility to schedule these appointments in advance. If I fail to schedule my appointments in a timely fashion, I understand that I may not be able to obtain my script(s).

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I certify that I am not undergoing treatment for substance dependence or abuse and that I am not currently abusing illicit or prescription drugs. **I will not share, sell, or trade my medication with anyone.**

I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medicines from any other physician unless previously discussed, documented and agreed upon with Advanced Pain Centers' physician. I understand that if I violate this that Advanced Pain Centers may void this agreement, discontinue any prescription of narcotic/opioid medications and discharge me from the clinic.

I certify that I am not pregnant and will notify the physician immediately if I become pregnant. I have been informed that Illinois law does not allow me to drive while taking any controlled medications.

I will safeguard my medications from loss or theft. I understand that lost or stolen medication will not be replaced and that a police report must be filed for the theft and a copy provided to Advance Pain Centers, S.C.

I agree that refills of my prescriptions for pain medication shall 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.

I agree to use only the following pharmacy:

Pharmacy Name: ______________________________________
Pharmacy Address: ____________________________________
Pharmacy Phone: ______________________________________

If for any reason I am unable to fill my prescription at this designated pharmacy, I agree to notify Advanced Pain Centers, S.C.

I authorize Advanced Pain Centers 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 medication. I authorize my physician to provide a copy of this Agreement to my pharmacy or any other healthcare provider from whom I seek care. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting healthcare operations of the practice. I further authorize Advanced Pain Centers access to my medical records at any other healthcare facility, institution or clinic where I seek care while I am a patient of Advanced Pain Centers. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I will bring all unused prescriptions at any time requested by my provider. I understand that I may have to consent to random urine or other drug tests for medications at the physician's request.

I agree to allow the physician to communicate with the referring physician, primary care physician, and any pharmacists regarding my use of controlled substances.

I understand that if I demonstrate unacceptable behavior patterns the physician may discontinue prescribing the narcotic/opioid medications and discharge me from the clinic. I understand that I must keep all follow-up appointments as recommended by my physician and that failure to comply may cause discontinuation of narcotic/opioid prescriptions and discharge from the clinic. I understand that I must adhere to the Treatment Policies of the practice and I have been given a copy of the policies.

I understand that the benefit of the narcotic/opioid medication will be evaluated periodically using the following criteria: degree of pain relief; increase in general functioning; increase in exercise activities; completion of rehabilitation program; return to work status; and maintenance of employment.

I agree to the terms of this Agreement that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this __________________ day of _______________, _______.

Patient Signature: ____

Printed Patient Name: ____

Physician Signature: ____

Witnessed By: ____

Printed Witness Name: ____