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PATIENT

AGREEMENT FOR NARCOTIC MANAGEMENT 2020/2021

Patient Name_____DOB_____

1) I understand that office progress notes will be shared with my referring doctor, and my primary care provider. I agree to continue to obtain regular check ups and preventative care. I consent to open communication between my pain doctor and my other medical care providers, pharmacists etc. Initial_____
My primary care provider is _____
2) I have been informed of the following: The long-term use of controlled substances is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of developing an addictive disorder or of relapse of addiction disorder. The extent of this risk is not certain. Narcotics may produce dependence, tolerance, and addiction. Side effects of narcotics include sedation, respiratory depression, alteration in hormones, hives, itching, impaired function, coma and death. For these reasons, we reserve the right to change to a non-narcotic therapy at any time it is indicated. I may need to wean off narcotics periodically. We also reserve the right to insist on treatment for narcotic dependence.
I agree to inform APMCI if I believe that I have an addiction of any kind, or if I am in need of medical detox. Initial_____
3) I attest that I have not been convicted of any drug or alcohol related crimes, such as DWI or illicit drug possession. Initial_____
4) I agree that only APMCI, Dr. Franiak or Melissa Franiak NP will prescribe narcotic pain medication for me. I understand that I have the right to seek a second opinion regarding my pain condition, however, I will have only one treating pain doctor. I agree not to ask for or obtain opioid (narcotic) medications from another doctor, this includes refilling prescriptions that were prescribed earlier. If I am scheduled to have surgery, I agree to inform APMCI in advance, and a plan for pain management will be arranged. Initial_____
5) Successful management of chronic pain may require a combination of treatments. I agree to comply fully with all aspects of my care. I understand narcotics are only a part of that plan. I agree that Dr. Franiak will perform required injections or interventional treatments for pain. We cannot maintain narcotic management if you are receiving interventional treatments from another pain doctor. Initial_____
6) I understand that APMCI uses a secure electronic prescribing system, at the time of my appointment. Prescriptions are not called/phoned in. In the event that I am given a paper form of the narcotic prescription, I will not write on it or alter it in any way. I understand that in accordance with Indiana State Law, APMCI will monitor controlled substances that are being filled in my name. Initial_____
7) I agree that I will not share, sell, or otherwise permit access to my medications. I understand that if my medication is lost or stolen, I will not be furnished with a replacement prescription. I agree to keep my medication secure and out of the access of children or dependents. Initial_____

8) I agree to comply with urine drug screens (UDS). I understand that UDS can be requested by APMCI randomly, or at every appointment. Presence of any illegal substances or opioids not prescribed by your pain doctor will result in dismissal and referral for substance abuse evaluation. THC, or marijuana, is an illegal substance in the State of Indiana. Initial_____
9) I agree to comply with random pill counts. This means I may be called to come in with the original bottle for pill count. Initial_____

10) I understand that alcohol can potentiate the side effects of narcotics. I agree not to drink alcohol while taking narcotic medications. Initial_____

11) I understand that some medications should not be used in combination with narcotics. I agree to inform Dr. Franiak or Melissa Franiak, NP of any new medications that are prescribed by other physicians. I understand that I am not to take medications intended to induce sleep or sedation, including over-the-counter sleeping medications, in combination with narcotics. I agree not to take benzodiazepines (Xanax, lorazepam, Valium, diazepam, Klonopin, clonazepam, Restoril, temazepam, etc) in combination with narcotics. Initial_____

12) Narcotic medications may be contraindicated with certain medical conditions. Narcotics are contraindicated in pregnancy. Narcotics are contraindicated with certain sleeping disorders. I understand I may be required to have a sleep study. I agree to inform APMCI of any and all medical conditions I have. Initial_____

14) I agree to take my medication as directed. I am informed that sudden discontinuation of narcotics may result in withdrawal symptoms, such as abdominal cramping, anxiety, sweating, tremors, nausea and elevated blood pressure. Therefore, it is wise to take the medication exactly as it is prescribed or wean off. Narcotic medications are not prescribed to avoid withdrawal symptoms. I may be required to wean off narcotic medications. Initial_____

15) I understand that missed appointments may result in fee's or dismissal from the practice. I agree to notify the office at least 24 hours in advance to cancel or change my appointment. This includes Telehealth appointments. Initial_____

16) I have been informed that opioids may cause drowsiness and interfere with the ability to safely drive or operate machinery. Employers often have policies in place regarding working under the influence of narcotic medications. It is my responsibility to know my employer's policies. I have been advised not to drive while taking narcotics. Initial_____

17) I understand it is the policy of this practice, that the patients treat our staff respectfully. Any behavior to the contrary may result in dismissal from the practice. Initial_____

18) I have read and agreed to the financial policy of the practice. I understand that co-pays are expected at the time of service. Balances will be settled prior to the next scheduled appointment. Initial_____

By signing this agreement, you affirm that you have read, understand and accept its terms. You also agree that all of your questions regarding treatment have been adequately answered. You give permission to your pain doctor to discuss and share information with other health care providers as it relates to providing you with coordinated, quality care. It is understood that if this agreement is not followed, we have the right to reduce and/or discontinue your narcotic medication, refer you to an addiction specialist, and/or dismiss you from the practice.

Patient Name_____ Patient Signature_____

Witness Signature_____Date_____