ALGONE DFW
INTERVENTIONAL PAIN
5860 Collin McKinney Parkway, Suite 604, McKinney, TX 75070

**Patient Name: _____ Date: _____**

## Controlled Substance Informed Consent & Treatment Agreement

***Please read the following information carefully*. This document outline's Algone Interventional Pain Clinic's urine drug screen policy.**

Algone Interventional Pain Clinic strives to provide the highest level of patient care and pain management to our patients. In doing so, many safeguards are utilized for monitoring to ensure safe medical practices. One such safeguard is the use of urine drug screens to analyze patient urine for use of prescribed and non-prescribed medications as well as illicit drugs.
Please note that all patients being seen by Algone will be expected to leave a urine sample. If a urine sample is unable to be left within 10 minutes of the patient's scheduled appointment time, the patient will have the option to have their blood drawn and tested in lieu of a urine drug screen.
If a patient is unable to leave a urine specimen for any reason or unwilling to give a blood sample, the patient will be permitted to see their provider but will not be given their prescription(s), if applicable, until a sample of urine or blood has been provided.

**Important** While every patient will be required to leave a urine or blood sample, not all samples will be run through the lab for confirmatory testing. A detailed review of patient's records by clinical personnel will establish whether or not that patient's sample will be run through lab, based on Algone Interventional Pain Clinic's Urine Drug Screen Policy, for confirmatory testing.

### CONTROLLED SUBSTANCE INFORMED CONSENT

**The following information pertains to controlled substance prescription medication therapy. Please read carefully and sign at the bottom to acknowledge and agree to the following statements. This consent will become effective on the date that Algone Interventional Pain Clinic takes over controlled substance medication management and/ or on the date Algone' s Interventional Pain Specialist begins you on a course of controlled substance treatment.**

I am signing this agreement for regularly prescribed controlled substance medications for chronic and/ or acute pain because other treatments and medications have not been sufficient in controlling my pain.
I understand that it is unlikely that any medication will completely take away my pain, however for humane reasons; controlled substance medications will be prescribed for me if my pain continues, provided that I follow the terms of this agreement.
I understand that there is no cure at this time for my pain problem and that there is no evidence nor guarantee that long- term controlled substance therapy will help me.

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**The following benefits, side effects, risks and terms have been discussed with me and by signing this agreement I understand and agree to the terms outlined below.**

Below is a summary of some of the possible benefits of controlled substance use:

- Improved state of control of pain and quality of life
- Increased capacity for physical activity
- Improved chance of returning to work
- Improved sleep
- Decreased reliance on other treatment modalities

Below is a summary of some of the common risks/problems of controlled substance use. I understand that if I experience any of the following, I will consult with my provider:

- Addiction
- Constipation
- Difficulty with urination
- Drowsiness
- Nausea
- Itching
- Decreased respiration
- Reduced sexual function
- Physical/Chemical dependence
- Impaired Alertness
- Impaired physical coordination

I understand that I may not be able to safely operate machinery or drive while taking controlled substance medications, particularly when I am started on the medication or during dose adjustments. I understand that I will have to make honest, careful judgments about my state of alertness, response times, attention, and physical coordination while taking this medication to minimize the risk of injury to myself and others.

I understand that it is my responsibility to report any prior history of controlled substance addiction or substance abuse to my physician; otherwise it may jeopardize my health.
I further understand that if I take more than the prescribed dose, a dangerous situation could result, such as coma, organ damage, or even death.

Algone commits to ensuring that a licensed and qualified covering provider will be available to care for unforeseen problems and to prescribe scheduled refills if the patient's normal pain care provider is out of the office.

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**Long-term controlled substance consent terms of agreement include:**

***Seeking or Obtaining Controlled Substance Prescriptions from Other Physicians or through the ER*:** I will not seek or obtain controlled substance prescriptions from any other practice(s) or through emergency care centers while I am under the care of my physician. I understand that if I do receive multiple controlled substance prescriptions from other facilities or physicians, I may lose my ability to be treated at Algone Interventional Pain Clinic, and I may be discharged.
***Accepting Controlled Substances and other Mind-Altering Substances from Non-Medical Provider*:** I will not use any illegal controlled substances, including, but not limited to, cocaine or heroin; I further agree that I will not use alcohol or other potentially mind-altering substances, even if those substances are not illegal, to the extent those substances cause me to act or function in a manner different from the way I act and function when I do not partake of those substances.
***Long-Term Use and Withdrawal*:** I understand that prolonged use of opiate medications can lead to physical dependence that is characterized by withdrawal symptoms if the medication(s) are suddenly discontinued. These symptoms can include sweating, nervousness, abdominal cramps, diarrhea, and alteration of one's mood.
***Dosage and Frequency of Use*:** I agree to take my medication as it was prescribed for me, and I will take it for the period of time for which it was prescribed. I agree not to use my medication for any purpose other than that for which it was prescribed.
***Lost or stolen medication*:** I understand that misplaced, lost, or stolen medications or prescriptions will not be replaced, and I take responsibility in safeguarding my medications and storing them properly. In the rare instance that a replacement is considered for lost or stolen medications, I will be required to produce a police report outlining the incident that resulted in the loss or theft of medications.
***Giving Away, Sharing, or Selling My Medication*:** I agree not to give away, share, or sell my medication with anyone, even family members.
***Masked Symptoms*:** I understand that the use of opioids may mask the signs and symptoms of other diseases or injury (including cancer) and I agree to undergo regular examinations by my family physician.
***Blood and/or Urine Drug Screens*:** I agree to periodic, unannounced examinations of my urine and/or blood in order to check for prescription compliance.
***Scheduled Appointments*:** I will arrive in a timely manner for my scheduled appointments. I understand that if I cancel and/or fail to show up for more than two scheduled appointments, that this is grounds for termination of treatment at Algone Interventional Pain Clinic.
***Refills*:** I understand that refills of controlled substance medications will be made only during regular office hours from 8:30-4:30 p.m., Monday-Thursday, 8:30-12:00 p.m. on Fridays. Refills will not be made at night or on holidays or weekends. I agree to call for refills of my medications at least 3 business days in advance of when they are due. In order to have my controlled substance prescription refilled, I must have been seen within the last 12 weeks at an office visit.
***Pill Counts*:** I will comply with requests by my medical provider to bring remaining tablets from the current prescriptions to the office between scheduled visits for a pill count. I understand that failure to appear to complete a pill count will be considered aberrant behavior and may be grounds for discharge.

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***Pregnancy (for female patients)*:** I certify that I am not pregnant, and do not plan to become pregnant and that I am taking all precautions, which may include use of contraceptives, to prevent my becoming pregnant while undergoing treatment. If I become pregnant, I will relay this information to my provider immediately.
***Assumed Risk*:** I acknowledge that my provider has informed me that controlled substances can decrease mental function and motor skills. I assume the risk and hold Algone Interventional Pain Clinic and its provider's harmless for operating any type of automobile, vehicle, machinery, or any potentially hazardous task and for making any important decisions, legal or otherwise, while taking opioids or controlled substances that are prescribed by my provider.
***Alternative Forms of Treatment*:** Alternative forms of treatment have been offered to me, and I have chosen to be treated with controlled substances for pain control.
***Violation of this Agreement*:** If I violate any provision of this Agreement, I understand that Algone Interventional Pain Clinic may immediately terminate me as a patient and immediately cease prescribing narcotics.
***Waiver of Rights*:** I waive my right to privacy or confidentiality so that my doctor can contact any health care provider or legal authority, federal, state, or local law enforcement, board of pharmacy or insurance company to obtain or provide information about my care.
***Agreement*:** I agree to follow the guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.
***Single Pharmacy*:** I agree to have all my prescriptions filled at a single pharmacy.

Name of my pharmacy: _____

Phone Number: _____

***Patient Acknowledgement:***

**I understand by signing this agreement that I am consenting to the terms and that I will be held responsible to follow the terms specified. I further understand that if I fail to follow the terms of this agreement, I will be discharged from Algone Interventional Pain Clinic.**

_____ _____

**Patient Signature** **Date**

_____ _____

**Staff Signature /Witness** **Date**