

treatment agreement

This agreement is between _____ and DuPage Valley Pain Specialists. It is agreed that narcotic/opioid medications will be prescribed by DuPage Valley Pain Specialists physicians as part of a treatment plan for myself only if the following terms and conditions are met:

- 1 The DuPage Valley Pain Specialists physician will discuss the use of narcotic medications with the patient, including the issues of appropriate and realistic goals, side effects and specific issues of developing tolerance, dependence, habitation, addiction and withdrawal problems due to these medications.
- 2 The patient has a chance to ask questions regarding the use of the narcotic/opioid medications and verbalizes understanding of the risks and benefits of using such medication.
- 3 **If DuPage Valley Pain Specialists are prescribing narcotic/opioid medication** then DuPage Valley Pain Specialists will be the ONE AND ONLY source of narcotic/opioid medications unless written permission is given by the DuPage Valley Pain Specialists physician for the patient to receive narcotic/opioid prescriptions from another physician. If it is found that the patient received prescriptions for narcotics/opioids from a source other than the DuPage Valley Pain Specialists physician without written permission, the physician will discontinue any prescription of narcotic/opioid medications to the patient.
- 4 Only ONE pharmacy will be used for filling narcotic/opioid prescriptions.
The name, address and telephone number of this pharmacy is listed below.

Pharmacy name: _____

Address: _____ Telephone number: _____

- 5 DuPage Valley Pain Specialists will NOT accept telephone requests for narcotic prescription refills. The patient assumes responsibility to schedule an office visit for medication refills *prior to* running out of the medication.
- 6 No prescription refills will be provided during the evenings or on the weekends. The patient agrees that refills of their prescriptions for pain medications shall be made only at the time of an office visit.
- 7 The patient understands 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 a rehabilitation program, return to work status and maintenance of employment.
- 8 The patient agrees to allow the DuPage Valley Pain Specialists physician to communicate with the referring physician, primary care physician and any pharmacists regarding the patient's use of controlled substances.
- 9 The patient understands that DuPage Valley Pain Specialists will NOT replace any lost or inaccessible narcotic/opioid prescriptions or medications for any reason. A police report must be filed for the theft and a copy provided to DuPage Valley Pain Specialists.
- 10 The patient must take the narcotic/opioid medication exactly as instructed by the DuPage Valley Pain Specialists physician/designee or in lower doses.
- 11 Any unauthorized increase in the dose of the narcotic/opioid medication may be viewed as a cause for discontinuation of the treatment with narcotic/opioid medications, and/or result in discharge from the DuPage Valley Pain Specialists.

- 12 The patient understands that narcotic/opioid medications can be discontinued immediately at the treating physician’s discretion, if the patient does not fulfill the terms of the agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.
- 13 The patient must keep all follow-up appointments as recommended by the DuPage Valley Pain Specialists physician. Failure to comply may cause discontinuation of narcotic/opioid prescriptions.
- 14 If the patient demonstrates unacceptable behavior patterns, the DuPage Valley Pain Specialists physician may discontinue prescribing the narcotic/opioid medications, and/or discharge from the DuPage Valley Pain Specialists.
- 15 The patient certifies or agrees to the following:
 - a That he/she is not currently abusing illicit or prescription drugs, and that he/she is not undergoing treatment for substance dependence or abuse.
 - b That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics/opioids, sleeping pills, nerve pills or painkillers).
 - c That she is not pregnant and that she will notify the physician immediately if she becomes pregnant during her course of treatment.
 - d That random urine tests for medications will be done at the physician’s request.
- 16 A DuPage Valley Pain Specialists Team member will witness the signature of the patient on this agreement and then the patient will receive a signed copy of this agreement.
- 17 By signing this Treatment Agreement form, the patient indicates that the form has been fully explained to him/her and he/she has understood the terms and conditions set by the DuPage Valley Pain Specialists. Any violation of this contract will result in discharge/termination from the DuPage Valley Pain Specialists. In this case, my physician may provide me with a 30 day prescription of appropriate medication deemed by the physician (provided medication was not already obtained from another provider(s), patient urine screen was negative for medications or positive for illicit medications), and any scheduled appointments during that 30 day period.

In summary: Evidence of medication hoarding, increasing the amount of medication without communication to the DuPage Valley Pain Specialists Team, refilling prescriptions too frequently, getting narcotics/opioids from multiple physicians, increasing the amount of medication despite significant side effects, altering prescriptions, medication or prescription sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription drugs in a way inconsistent with its labeled use) during narcotic/opioid analgesic treatment or other unacceptable behavior will result in tapering and discontinuation of the narcotic/opioid maintenance therapy.

Printed patient’s name: _____

Patient signature: _____ Patient initials: _____

Date: _____

Printed witness name: _____ Witness signature: _____

Date: _____