Opioid Treatment Agreement

Advanced Pain Solutions, PLLC

The purpose of this agreement is to prevent confusion about medicines you will be taking for pain management. This is to help both you and your physician to comply with the laws regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship that my physician undertakes to treat me based on this agreement. I will tell Dr. Camp and associates all medicines which I am prescribed and understand that mixing medications which have not been prescribed to me by my physician can result in bodily harm and possibly death.

I understand that if I break this agreement, my physician will stop prescribing this class of pain medicines. In this case, my physician may taper me off of the medicine over a period of time that is appropriate to avoid withdrawal symptoms. I also realize that a drug-dependence treatment program may be recommended in conjunction with an opioid taper.

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 medicine is helping to improve my overall functionality and ability to complete activities of daily living.

I will not use any illegal substances including but not limited to the following: marijuana, cocaine, heroin, etc.

I understand that if I am pregnant or becoming pregnant while taking these opioid medications, my child may be physically dependent on these medications and withdrawal can be life-threatening.

I will not share, trade, or sell my medication with anyone.

I understand that my opioid medication will be prescribed by one physician and I agree to fill my prescription at only one pharmacy. I agree not to take any pain medications or mind-altering medications prescribed by any other physician without first discussing it with Dr. Camp and associates. I give my physician permission to verify that I am not seeing other physicians for opioid medications or going to other pharmacies.

I agree to store this medication safely and understand that lost, stolen or misplaced medication may not be replaced without a valid police report.

I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing physician. Running out early, needing early refills, escalating doses without permission are signs of misuse and may be reason for this physician to discontinue this agreement.

I agree that refills of my opioid medications will be made only at my scheduled office visits. I also agree to make a return office visit prior to my prescriptions end. I will bring all used and unused medications with me to each of my appointments and realize that my failure in doing so can end this opioid agreement. No refills will be provided without a scheduled appointment.

I will go to all appointments, treatments and meetings that my physician wants me to, such as Behavioral Health.

I have been instructed that I will be asked to provide urine samples randomly to insure I am taking the appropriate medications and avoiding medicines or drugs which are not being prescribed by the above mentioned physician.

I agree that disruptive behavior in the clinic, by telephone, or other electronic media will result in immediate dismissal from the Pain Clinic.

I understand that opioid medications have numerous side effects including but not limited to the following: confusion, changes in thinking ability, decreased reaction time, constipation, dry mouth, vomiting, aggravation, depression, sleepiness, drowsiness, problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles, hormonal imbalance (feminization in men, masculinization in women), decreased respiratory rate, addiction and death. These side effects can be made worse if opioids are taken with other drugs including alcohol.

I understand that there is a risk that opioid addiction can occur. People with a past history of alcohol or drug abuse problems are more susceptible to addiction. Should I exhibit signs of addiction the medications I'm being prescribed will be discontinued and I will be referred to a drug treatment program for help with this problem.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
(Representative and relation)	Signature	Date
Adam Camp, MD _____	_____	_____
Provider	Signature	Date