Medication Management Agreement

The decision to use opioid (narcotic) medications was made because of my specific condition or because other treatments have not helped my pain. Because BCT MEDICAL ASSOCIATES and its Physicians (hereinafter referred to as BCT MEDICAL ASSOCIATES) are prescribing such medication for me to help manage my pain, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible. **Please initial each numbered item:**

_____ 1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia (pain reduction), addiction, and the possibility that the medicines will not provide complete pain relief.

_____ 2. I understand that the main treatment goal is to improve my ability to function by reducing pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my pain management treatment.

_____ 3. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be fully determined and that treatment may change while I am under BCT MEDICAL ASSOCIATES's care. I understand, accept, and agree that unknown risks may be associated with the long-term use of controlled substances and that my physician will advise me as knowledge and training advances are made, and will make appropriate treatment changes. I also know there may be other non-opioid options for my pain control.

_____ 4. I agree to tell my doctor about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other physician or individual** while I am receiving such medications from BCT MEDICAL ASSOCIATES. To do so may endanger my health and/or our physician/patient relationship. The only exception is medication prescribed while I am admitted to a hospital or post-surgical.

_____ 5. I understand that if I am pregnant or become pregnant while taking opioid medications, my child would be physically dependent on opioids and withdrawal can be life threatening for a baby.

_____ 6. I understand the following refill policy:

- ***a. The daily dose may not vary. The weekly/monthly dose must remain constant.***
- ***b. Medications will not be refilled early, even if they have been lost.***
- ***c. Medications will not be refilled on Fridays, weekends, or holidays.***
- ***d. Medications will not be refilled by other physicians.***

_____ 7. I agree to use pharmacy, located at for all my pain medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.

_____ 8. I agree to **keep all scheduled appointments**.

_____ 9. At each visit, BCT MEDICAL ASSOCIATES will evaluate me for pain relief, side effects, function, and abnormal behavior (anything indicating addiction). I agree to adhere strictly to medical instructions and laws governing the use of these medications, I authorize BCT MEDICAL ASSOCIATES to test my blood or urine for the presence of illicit substances without prior notice and agree to submit to psychiatric or drug abuse evaluation should BCT MEDICAL ASSOCIATES request it. I must keep BCT MEDICAL ASSOCIATES fully informed

of any changes, Emergency Room visits, lost or stolen medications or any other circumstances affecting my health and well-being.

_____ 10. BCT MEDICAL ASSOCIATES may refer me to another physician for a second opinion while I am receiving controlled substances. I understand that if I do not obtain this second opinion, BCT MEDICAL ASSOCIATES may discontinue my medications or refill them with a tapering dose to therapeutically and safely discontinue my use of them.

_____ 11. You have my permission to discuss my ***(medical condition/medication management)*** with my spouse or significant other. Name:

_____ 12. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.

_____ 13. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for themself.

_____ 14. I have been fully **informed** by BCT MEDICAL ASSOCIATES regarding the potential psychological **dependence** on a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

15. I understand that I must make necessary arrangements to alert BCT MEDICAL ASSOCIATES of my need for a refill ***five (5)*** working days before they run out. **Meds Will NOT BE Refilled on the weekend. They will not be called in to the pharmacy. Patient will have to come to the clinic for Script pick up during business hours.**

16. Patient fully understands the use of Illegal substances according to Federal Government standards will cause immediate termination from the practice.

17. I understand that it is illegal to furnish controlled substances prescribed for my use to any person (family or non-family) for any reason. I further understand that furnishing these medications is equivalent to narcotic distribution which is a felony in this country. I agree to take strict precautions to prevent unauthorized access to my medications.

_____ 18. **I understand that if I fail to comply** with the guidelines in this agreement and on my prescription labels; if I obtain narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.

I have read this agreement. I fully understand that failure to do so will lead to termination of this treatment. BCT MEDICAL ASSOCIATES has answered my questions and I agree to the terms of the agreement.

Patient name: _____

Patient signature and date: _____

Witness signature and date: _____

□ Copy given to patient