PIERCEY NEUROLOGY

Together we can unleash the cure!™

Informed Consent Agreement for Treatment with Controlled Medication

PATIENT NAME _____ DOB: _____

The purpose of this agreement is to provide information about the medications I will be taking for pain management and to assure that I and my physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for me to have the best quality of life possible give the reality of my clinical condition. The success of the treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using controlled substances to treat pain. I understand that there are alternative treatments which may include but may not be limited to: Nonnarcotic medication, Physical therapy, Injections, Surgery, Pain management referral, Acupuncture.

Notice of Risk: The use of controlled substances may be associated with certain **risks such as, but not limited to**:

1. **Central Nervous System**: Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.
2. **Cardiovascular**: Irregular heart rhythm from mild to severe.
3. **Respiratory**: Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.
4. **Gastrointestinal**: Constipation is common and may be severe. Nausea and vomiting may occur as well.
5. **Dermatological**: Itching and rash.
6. **Endocrine**: Decreased testosterone (male) and other sex hormones (females); dysfunctional sexual activity.
7. **Urinary**: Urinary retention (difficulty urinating).
8. **Pregnancy**: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth
9. **Drug Interactions** with or altering the effect of other medications cannot be reliably predicted.
10. **Tolerance**: Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect.
11. **Physical dependence and withdrawal**: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized malaise (flu-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need to be slowly weaned (tapered off) under the direction of your physician.
12. **Addiction (Abuse):** This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.
13. **Allergic reactions**: Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications
14. Patient is given the following reference and is encouraged to learn about the medication prescribed: http://www.nlm.nih.gov/medlineplus/druginformation.html

I agree to the following guidelines:

1. I will take this medication as prescribed by my provider. I will not vary the dosage or interval without authorization from my provider. I will not accept pain medications from any other practitioner without notifying Piercey Neurology.
2. I will submit to random urine or blood tests as requested to assess my compliance. I understand there may be associated financial charges with this testing and I agree to pay the remaining balance not paid for by my insurance company. If I do not have insurance I agree to pay the cost of testing in full at the time of visit. Failure to follow the agreement may result in no further prescriptions being provided, tapering the medication dose and/or termination of the doctor/patient relationship.
3. I will obtain all my prescriptions for pain medication and controlled substances through Piercey Neurology and will fill all prescriptions at one pharmacy.

PHARMACY: _____ PHONE NUMBER: _____

In a true medical emergency another provider may prescribe medications for me. If this occurs I will notify my Piercey Neurology as soon as possible.

4. I may not give or sell my medications to any other person under any circumstances. If I do, I may endanger that person's health. It is also against the law. Any evidence of drug hoarding, acquisition of any controlled substances or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in tapering the medication dose of termination of the doctor/patient relationship.
5. I am responsible for keeping my pain medication in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. Stolen medications should be reported to the police and to my physician immediately. Due to the potential for misuse, I know that I will be unable to obtain early refills or replacement of lost or stolen medication. Refills will only be made during regular office hours and must be requested at least 48 hours before I run out.
6. I agree to see a Piercey Neurology provider for-on-going case management and will schedule regular appointments as long as I am taking this narcotic medication.
7. I agree to inform my physician of all medications I am taking, including herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone. PIERCEY NEUROLOGY will not prescribe controlled substances to patients using medicinal or recreational marijuana in any form.
8. If asked at any time, I must bring back all controlled substances and adjunctive medications prescribed by my physician in the original bottles.
9. I will communicate fully to my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medication This information allows my physician to adjust my treatment plan accordingly.
10. I should not use any illicit substances while taking these medications. This may result in a change to my treatment plan, including safe discontinuation of my controlled substances when applicable or complete termination of the doctor/patient relationship.
11. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with controlled substances for pain may increase the possibility of relapse.
12. I agree to allow my physician to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the physician feels it is necessary.
13. I must provide the office with an updated phone number that I can be reached on at all times. If I change my phone number, I need to inform the office of the change as soon as possible.

If I do not follow these guidelines I understand that my treatment may be terminated.

I have discussed the risks, benefits and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

These regulations have been agreed upon by all provider's in our practice.

Sydney Piercey, MD Allen Brooks, MD John Emmett, PA-C Jaime Conway, PA-C John Taylor, PA-C

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Patient Signature Date Witness Signature Date