Interventional Pain Physicians Of South Florida

Nancy Erickson, D.O.

PAIN MANAGEMENT AGREEMENT

PLEASE BE SURE TO READ, BREACH OF THIS CONTRACT MAY RESULT IN BEING DISCHARGED FROM MY PRACTICE.

Our goal in the field of Pain Management Medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. We strive to manage pain through means other than medications to allow patients to live a relatively pain free life. We seek to treat the cause of the pain and not the symptoms. **However, we also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this Agreement is to clarify the conditions under which Dr. Nancy Erickson will prescribe medications for you. This agreement will help you and Dr. Nancy Erickson comply with the laws regarding controlled pharmaceuticals and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each and every item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS OF ANY AND ALL PRESCRIPTIONS:
Please Initial that you have read and understand each number below.

1. I WILL USE MY MEDICATION(S) AT A RATE NO GREATER THAN THAT PRESCRIBED BY DR. NANCY ERICKSON. IF I DO OVER-USE MY MEDICATION, THAT MEDICATION WILL NOT BE REFILLED EARLY, AND I MAY BE WITHOUT PAIN MEDICATION FOR SOME PERIOD OF TIME. _____

2. I WILL NOT SHARE, SELL OR TRADE MY MEDICATION WITH ANYONE. I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICINCES, INCLUDING OPIOID PAIN MEDICINES, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICINES FROM ANY OTHER DOCTOR. I WILL SAFEGUARD MY WRITTEN PRESCRIPTIONS AND PAIN MEDICINE FROM LOSS OR THEFT. I UNDERSTAND THAT LOST OR STOLEN WRITTEN PRESCRIPTIONS OR MEDICINES WILL NOT BE REPLACED. _____

3. SUDDEN DISCONTINUATION OF A NARCOTIC PAIN MEDICATION MAY LEAD TO UNPLEASANT OR DANGEROUS WITHDRAWL SYMPTOMS. _____

4. THE POTENTIAL RISKS AND SIDE EFFECTS OF MEDICATIONS TAKEN FOR PAIN, EITHER SHORT TERM OR LONG TERM, CAN INCLUDE: DROWSINESS, NAUSEA, CONSTIPATION, ITCHING, DIFFICULTY WITH URINATION, TOLERANCE, DEPENDANCE, ADDICTION, AND OVERDOSE. _____

5. IN THE EVENT THAT DR. NANCY ERICKSON FEELS THAT YOUR DOSE OF PAIN MEDICATION IS EXCESSIVE OR MAKES THE DIAGNOSIS OF ADDICTION OR OVERDOSE, DR. NANCY ERICKSON WILL REDUCE THE MEDICINE OVER A PERIOD OF TIME (DAYS, WEEKS, AND MONTHS) AS NECESSARY TO AVOID WITHDRAWL SYMPTOMS. ALSO, A DRUG-DEPENDENCE TREATMENT OR DETOXIFICATION PROGRAM MAY BE RECOMMENDED. _____

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6. I UNDERSTAND AND AGREE THAT I AM NOT TO RECEIVE ANY TYPE OF PRESCRIPTION PAIN MEDICATION OR SEDATIVE MEDICATION FROM ANY PHYSICIAN OTHER THAN DR. NANCY ERICKSON UNLESS THERE IS A SPECIFIC MEDICAL NECESSITY. SHOULD YOUR CAREGIVER OR YOU RECEIVE ANY PAIN OR SEDATIVE MEDICATIONS FROM ANY OTHER PHYSICIAN, YOUR CAREGIVER OR YOU MUST INFORM DR. NANCY ERICKSON'S OFFICE EITHER BY TELEPHONE OR IN WRITING WITHIN 72 HOURS OF HAVING FILLED THE PRESCRIPTIONS. _____

7. REFILLS OF YOUR PRESCRIPTIONS WILL BE ISSUED ONLY AT THE TIME OF AN OFFICE VISIT, DURING REGULAR OFFICE HOURS, OR IMMEDIATELY FOLLOWING A PROCEDURE._____

8. REFILLS WILL NOT BE AVAILABLE DURING EVENINGS, ON WEEKENDS OR HOLIDAYS. _____

9. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY SUPPLY OF PAIN MEDICATION AND TO MAKE TIMELY APPOINTMENTS WITH DR. NANCY ERICKSON TO HAVE YOUR PRESCRIPTION(S) REFILLED. **LAST-MINUTE REQUESTS FOR PRESCRIPTION REFILLS ARE NOT WELCOME. _____**

10. DR. NANCY ERICKSON MAY, AT HER DISCRETION, ISSUE A CHANGE OF YOUR MEDICATION(S) BASED ON A TELEPHONE CONVERSATION THAT SHE HAS HAD REGARDING YOUR PAIN CONDITION AND THE EFFECTS THEY MAY HAVE ON THIS CONDITION. _____

11. I WILL COMMUNICATE FULLY AND TRUTHFULLY WITH DR. NANCY ERICKSON 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 RELIEVE THE PAIN. I UNDERSTAND THAT I, OR MY CAREGIVER IS RESPONSIBLE FOR INFORMING DR. NANCY ERICKSON EITHER IN PERSON, AT THE FOLLOW-UP, OR BY TELEPHONE AT DR. NANCY ERICKSON'S OFFICE AT (954-433-8711) DURING REGULAR BUSINESS HOURS (7:00 A.M.- 3:30 P.M., MONDAY THROUGH THURSDAY, REGARDING ANY PROBLEMS OR SIDE EFFECTS ENCOUNTERED WITH THE MEDICATION. A MESSAGE MAY ALSO BE LEFT FOR DR. NANCY ERICKSON AT (954-433-8711) REGARDING ANY OF THESE PROBLEMS. _____

12. I HAVE BEEN ADVISED TO ABSTAIN FROM OR SIGNIFICANTLY MODERATE MY USE OF **ALCHOLIC BEVERAGES** WHILE TAKING MEDICATION FOR MY PAIN CONDITION. I WILL NOT USE ANY ILLEGAL CONTROLLED SUBSTANCES, INLUDING MARIJUANA, COCAINE, HEROIN, ECSTASY, GHB, ETC. IF I AM A **CIGARETTE SMOKER**, I UNDERSTAND THAT I WILL BE ASKED TO QUIT. CIGARETTE SMOKERS TYPICALLY HAVE A DECREASED RESPONSE TO PAIN TREATMENT BECAUSE OF THE EFFECTS OF SMOKING ON OXYGEN DELIVERY TO THE PERIPHERAL TISSUES. ADDITIONALLY, **OBESITY** IS ONE OF THE MOST IMPORTANT CAUSES OF FAILED TREATMENT FOR CHRONIC PAIN. EVERY TEN POUNDS OF EXCESS WEIGHT THAT ONE CARRIES ON HIS/HER BODY RESULTS IN ONE HUNDRED POUNDS OF INCRESASED PRESSURE ON THE SPINE, VERTEBRAL DISCS, AND SPINAL NERVES. EXCESSIVE WEIGHT WILL THEREFORE RESULT IN AN INCREASE IN PAIN. PHYSICAL THERAPY WILL ALSO BE DIRECTED IN THIS AREA AS WELL. _____

13. IF PHYSICAL THERAPY IS PRESCRIBED, I AGREE TO ATTEND AND PARTICIPATE TO THE FULLEST EXTENT POSSIBLE. IF THERE ARE ANY PROBLEMS WITH MY PHYSICAL THERAPY, I AGREE TO COMMUNICATE THIS TO DR. NANCY ERICKSON SO THAT SHE CAN MAKE THE APPROPRIATE CHANGES IN MY THERAPY PROGRAM. _____

14. I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY DR. NANCY ERICKSON TO DETERMINE MY COMPLIANCE WITH MY REGIMEN OF PAIN MEDICATION. FUTHERMORE, AT DR. NANCY ERICKSON'S DISCRETION, THE PRIMARY CAREGIVER WHO'S SIGNATURE APPEARS BELOW SHALL ALSO BE SUBJECT TO PERIODIC URINE AND/OR BLOOD TESTING. _____

15. IF REQUESTED, I WILL BRING ALL UNUSED PAIN MEDICINE TO AN OFFICE VISIT FOR A "PILL COUNT". DR. NANCY ERICKSON MAY REQUEST ADDITIONAL "PILL COUNTS" AT ANY TIME, AND I AGREE TO COMPLY WITH THESE REQUESTS. I AGREE THAT MY CAREGIVER OR I WILL BRING THE MOST RECENT PRESCRIPTION CONTAINER FOR EACH MEDICATION TO EACH VISIT WITH MY PHYSICIAN. THESE CONTAINERS MUST CORRESPOND TO THEIR LAST PRESCRIPTION RECORDED IN THE MEDICAL RECORD WITH THE PRESCRIPTION LABELS INTACT AND LEGIBLE SO THAT DR. NANCY ERICKSON OR STAFF MEMBER MAY DOCUMENT APPROPRIATE CONTROL INFORMATION. SPECIFICALLY, THE PRESCRIPTION REGISTRATION NUMBER AND PHARMACY TELEPHONE NUMBER WILL BE NOTED AND VERIFIED. _____

16. I FURTHER UNDERSTAND THAT THIS AGREEMENT IS ESSENTIAL TO THE TRUST AND CONFIDENCE NECESSARY IN A DOCTOR-PATIENT RELATIONSHIP AND THAT DR. NANCY ERICKSON UNDERTAKES TO TREAT YOU BASED ON THIS AGREEMENT. I UNDERSTAND THAT IF I BREAK THIS AGREEMENT OR PROVIDE ANY FALSE INFORMATION, DR. NANCY ERICKSON WILL STOP PRESCRIBING THESE PAIN-CONTOL MEDICINES AND YOU MAY BE IMMEDIATELY REMOVED FROM DR. NANCY ERICKSON'S CARE. _____

I have reviewed all of the items contained in this four (4) page agreement. I agree to follow all of the guidelines that are described above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me <u>upon request</u>. I voluntarily consent to participation in the pain medication program described in this Agreement.

I WILL USE ONLY ONE PHARMACY TO FILL PRESCRIPTIONS FOR YOUR PAIN MEDICATIONS. **MY PHARMACY IS (NAME) _____PHONE: _____ PHARMACY LOCATION (STREET/CITY): _____** I AUTHORIZE DR. NANCY ERICKSON AND MY PHARMACY TO COOPERATE FULLY WITH ANY CITY, STATE, OR FEDERAL LAW ENFORCEMENT AGENCY, INCLUDING THIS STATE'S BOARD OF PHARMACY, IN THE INVESTIGATION OF ANY POSSIBLE MISUSE, SALE OR OTHER DIVERSION OF MY PAIN MEDICATION. I AUTHORIZE DR. NANCY ERICKSON TO PROVIDE ME A COPY OF THIS AGREEMENT TO MY PHARMACY. I AGREE TO WAIVE ANY APPLICABLE PRIVILEGE OR RIGHTS OF PRIVACY OR CONFIDENTIALITY WITH RESPECT TO THESE AUTHORIZATIONS. I FURTHER CONSENT TO DR. NANCY ERICKSON CONTACTING OTHER PHYSICIANS TO DISCUSS PRIOR PRESCRIPTIONS THAT I HAVE RECEIVED FROM THOSE PHYSICIANS OR TO OBTAIN THE RESULTS OF DIAGNOSTIC TESTING (PAST OR PRSENT) IN ORDER TO OBTAIN ADEQUATE INFORMATION ABOUT MY CONDITION. _____

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CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Interventional Pain Physicians will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, IPP will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that the prescription history will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative**:** _____

Date: _____

*****PLEASE BE ADVISED I CANNOT SEND YOUR PRESCRIPTIONS TO MULTIPLE PHARMACIES. ONCE YOUR PRESCRIPTION IS SENT I CANNOT CHANGE THE PHARMACY FOR ANY REASON. BE SURE THAT YOUR PHARMACY HAS YOUR MEDICATION IN STOCK AND OR IT CAN BE ORDERED. THIS MEANS YOU MAY RUN OUT OF MEDICATION. _____**

For the protection of our patients it is our office policy to perform periodic drug and alcohol screenings. If you are requested to give us a urine/saliva sample it is to be given at the time it is requested. You will not be able to leave and return at a later time to provide a sample. If you choose not to give us a urine sample upon request, we will continue to treat your pain with interventional procedures appropriate for your specific problems, however, we will no longer write pain medications for controlled substances. We are here to help you get better and for your safety, we will continue to do this by helping you to have appropriate medication levels

I understand that my physician has requested that I be tested to determine the level of drug or metabolite in my body.

I further understand and agree that the testing will be performed in the physician's office and/or sent to an outside laboratory as needed, on a specimen of my urine that I provide for the purpose of this drug test.

I understand and agree that the outside laboratories used and my physician will maintain the confidentiality of my urine drug test results.

I understand that the test results and interpretation will become part of my medical record. I understand that an insurance company may discover the results of this test by informing them of this test or by obtaining a copy of my medical record from my physician.

I understand that I will be solely responsible for any financial balance to the outside laboratory and/or the physicians office should the drug screening not be covered in part or in full by my insurance company.

All of the above have been discussed with me and I have had an opportunity to have any questions answered that I have regarding the drug testing or my rights to privacy.

Patient Signature: _____ Date: _____

(If applicable) Legal Guardian Name: _____ Legal Guardian Signature: _____

Witness Name: _____ Witness Signature: _____

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