ANESTHESIOLOGY OF JUPITER d/b/a JUPITER PAIN MANAGEMENTI

PAIN MANAGEMENT CONTROLLED SUBSTANCE ACKNOWLEDGEMENT AND AGREEMENT

The purpose of this agreement is to ensure that the patient has given accurate information upon which the doctor can rely in implementing a pain management program. It is also to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician comply with the law regarding controlled pharmaceuticals.

_____ (Initial) I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

_____ (Initial) I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications, I will be discharged from my doctor's care, and I may be criminally prosecuted. A drug dependence treatment program may be recommended.

_____ (Initial) I will communicate fully with my doctor and staff about the character and intensity of my pain, the effects of the pain on my daily life, and how well my medicine is helping to relieve my pain.

_____ (Initial) I will not use any illegal controlled substance, including marijuana, cocaine, etc.

_____ (Initial) I will not share, sell or trade my medication with anyone.

_____ (Initial) I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor, unless coordinated with this office.

_____ (Initial) I will safe guard my medicine from loss or theft. I understand that lost or stolen medication will not be replaced.

_____ (Initial) I agree that refills of my medication will only be available during my regularly scheduled office visits. I understand that it is my responsibility to make and keep timely appointments. Prescriptions will not be phoned in or picked up out side of these visits. Refills will not be available during evenings, weekends or holidays. **Refills require a minimum of (3) days = 72 hours notice.**

_____ (Initial) I authorize the doctor, facility and pharmacy to cooperate fully with any city, county, state or federal law enforcement agencies, in the investigation of any possible misuse, sale or other diversion of my medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care provider and referring physician. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ (Initial) I agree that I will submit to urine or blood tests (at my own expense) as requested by my doctor to determine my compliance with my program of pain control medication.

_____ (Initial) I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

_____ (Initial) I understand that my pain medications have the potential to impair my judgment and caution should be used when driving or operating heavy machinery, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself. I understand I should not drive a motor vehicle while taking narcotic medications and may be charged with 'Driving Under the Influence' if stopped by law enforcement officials.

_____ (Initial) I understand that alcohol may increase the effects and duration of my medication. I acknowledge that I have been advised to avoid alcohol consumption.

_____ (Initial) I have been fully informed of the psychological dependence (addiction) of 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 same effect of pain control, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and, when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

_____ (Initial) I understand that it is a criminal offense in the State of Florida to acquire or obtain or attempt to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge. I understand that if I make any false statements in this agreement, I will be subject to criminal prosecution.

MALES ONLY

_____ I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may send me to have my blood checked to see if my testosterone level is normal and will refer me to the appropriate physician for follow-up if it is not.

FEMALES ONLY

_____ If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

1. I am not exaggerating any of the symptoms of any condition that requires pain management. I have been completely honest with my doctor regarding any condition that requires pain management.

_____
Patient Signature

2. I will not see any other physician regarding any condition that requires pain management unless I notify my doctor prior to visiting the other physician.

_____
Patient Signature

3. If my doctor prescribes pain medications, I will only use _____ pharmacy to fill prescriptions. If I intend to use any other pharmacy I will notify my doctor immediately.

_____
Patient Signature

Patient abuse of medication is a serious problem. Please read this form carefully, you will be held to this agreement by your physician and by any law enforcement agency investigating any possible abuse of the doctor/patient relationship with regard to pain management.

I do hereby state that I have read this form completely, and that all of the information is true and accurate. I understand that any false statements given in conjunction with this agreement will subject me to criminal prosecution. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____day of _____month, _____year

Patient Signature: _____

Witness: _____

Physician: _____

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