Oklahoma Joint Reconstruction Institute
Paul B. Jacob, DO

PATIENT-PROVIDER AGREEMENT FOR CHRONIC PAIN TREATMENT

The purpose of this Agreement is to give the patient information about certain medications the patient will be taking for chronic pain management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines, and stimulants may cause addiction and is only one part of a complete treatment plan.

B. Chronic Pain: Pain that persists beyond the usual course of an acute disease or healing of an injury. "Chronic pain" may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. The state of Oklahoma defines chronic pain as an episode of pain lasting longer than 2 weeks.

I agree to the following:

1. I am being prescribed an opioid pain medication, as part of my treatment plan to manage my chronic pain. The pain I am experiencing may be improved, but not eliminated, with the use of these opioid medications.
2. Opioids are a type of powerful pain medication often called narcotics. They can be very useful in managing pain, but they have a high potential for dependency and addiction.
3. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will store opioid medications in a secure location to prevent others from taking them and will safely dispose of them when I am no longer using them.
4. I will not take any medicine not prescribed to me.
5. Forging or altering a prescription or distributing medications to others is a crime. I understand that should any of the above occur, my care with this office will be terminated and I will be reported to law enforcement authorities.
6. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
7. I will not increase my medicine until I speak with my doctor or nurse.
8. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
9. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
10. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
11. I agree to come to the office for a pill count at any time if asked by my doctor.
12. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
13. I will inform my doctor about all other medicines I am taking. Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system depressants is highly dangerous and can be fatal.
14. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit and again randomly through the course of my treatment.
15. I understand that my doctor will use the Oklahoma Bureau of Narcotics and Dangerous Drugs Prescription Monitoring Program.
16. There are several risks of opioid medications that my treating physician has discussed with me. Some of those risks include sleepiness or drowsiness, impaired mental or motor ability, slowing of breathing rate, skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, swelling, physical or psychological dependence, tolerance to analgesia (meaning you require more medicine to get the same pain relief), and addiction. Opioid medications are highly addictive even when taken as prescribed. Overdose of opioid pain medication can lead to breathing difficulty and even death. Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system depressants is highly dangerous and can be fatal. It is my responsibility to inform my treating physician about all other medicines I am taking.
17. I should not drive an automobile or operate any machinery when taking opioid medications.
18. I understand that opioid medications can adversely affect my judgment in making business decisions.
19. My treating physician has discussed with me alternative pain management approaches that may be available to manage my pain instead of
20. taking opioid pain medications and the risks and benefits of the alternatives.
21. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control, and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
22. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence

9800 Broadway Ext. Suite 201 ● Oklahoma City, Oklahoma 73114 ● Phone (405) 424-5426 ● Fax (405) 424-5431
www.OJRI.com ● www.drpauljacob.com ● www.robotichipandkneereplacement.com ● www.jointsensor.com

that I am improving, or that progress is being made to improve my function and quality of life, my medication regime will be tapered, and my care will be referred back to my primary care physician.

23. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

PRESCRIPTION REFILL POLICIES:

- You understand that you **must be assessed by our providers prior to every opioid prescription refill**.
- Refill requests are only accepted Monday – Friday from 8:00 AM to 3:30 PM **No exceptions will be made.**
- **No refill requests will be accepted AFTER 3:30 PM**
- **No refill requests will be accepted on SATURDAYS or SUNDAYS**
- **No refill requests will be accepted ON HOLIDAYS**
- You understand that IT IS **YOUR RESPONSIBILITY** to monitor your pain medication. **Early refills are not permitted**
- You understand that IT IS **YOUR RESPONSIBILITY** to check with your pharmacy to confirm your refill is ready for pick-up
- You must inform your provider of any changes in other prescribed or OTC medications, medical condition, surgical history, relevant family history, social history, or civil actions related to the use of opioids, narcotics, alcohol, or illegal substances.
- You agree to comply with **medication compliance monitoring** as needed. These include, but are not limited to:

- **Random pill counts** may be required and must be responded to within the given timeframe. If you live outside of a 60-mile radius from our office, your local pharmacy or doctor's office may perform the requested pill count and report the results to our office. Counts that are inconsistent or failure to comply with a requested pill count will be viewed as non-compliance and may result in dismissal from this practice.
- **Random urine or blood drug screenings** may be requested. Presence of illegal, unauthorized substances, absence of prescribed medications or other abnormal results may result in discontinuation of your controlled medications. Failure or refusal to provide a sample for drug testing will be viewed as non-compliance and may result in dismissal from our practice.
- Should any of the above occur, my entire care with this office will be terminated and I will be reported to law enforcement.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain opioids from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if opioids have been obtained from another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors, or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

INFORMED CONSENT

I, ____, have been informed and clearly understand the above listed issues regarding the treatment of pain with opioid pain medications for both acute and chronic conditions. I acknowledge that I have read and understand this agreement. The pain management treatment plan has been discussed, understood, and agreed to myself and my physician. All questions or concerns have been answered or addressed to my satisfaction. I also understand that I have the right to talk about this agreement with my physician. I understand the reason why this prescription is necessary, the alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me and I still desire to receive medications for the treatment of my pain. I agree to comply with the terms contained herein and understand that failure to do so may result in termination of the physician/patient relationship and/or termination from this medical practice. I understand that this agreement will be filed in my chart as part of my permanent medical record.

____

Patient Signature | Patient Printed Name | Date

____

Witness Signature | Witness Printed Name | Date

____

Dr. Paul B. Jacob | Date

9800 Broadway Ext. Suite 201 ● Oklahoma City, Oklahoma 73114 ● Phone (405) 424-5426 ● Fax (405) 424-5431
www.OJRI.com ● www.drpauljacob.com ● www.robotichipandkneereplacement.com ● www.jointsensor.com