



# Oklahoma Joint Reconstruction Institute

## Paul B. Jacob, DO

## **OPIOID THERAPY INFORMED CONSENT FOR TREATMENT**

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. It is also meant to prevent misunderstandings about certain medicines the patient will be taking for pain management. This is to help both the patients and their provider comply with the law regarding post-surgery pain management. Please read this contract thoroughly as it is a condition of any treatment requiring narcotic pain medication or other controlled substances. Your signature will also be required prior to initiating any treatment involving controlled substances.

Our goal is to provide you with the best quality treatment of your pain. To accomplish this goal, your physician will customize your treatment plan to best fit your healthcare needs. Your pain management treatment plan may include, but is not limited to, injection therapy, physical therapy, medication therapy, psychological counseling, relaxation therapy and exercise and weight loss programs. When opioids and other controlled medications are the best option, it is important to review and follow the policies to ensure your safety and our continued ability to treat you in the most effective way possible.

**Please read this carefully, as these policies will be enforced. If you do not understand any of the information below or require additional clarification on the policies of this practice regarding prescribed medication, please ask prior to signing the agreement. You are required to sign this agreement stating your understanding and compliance before receiving any pain medication.**

Dr. Jacob and his physician assistants **do not** prescribe pre-operative opioid based pain medication. If you require pre-operative opioid based pain medication prior to your surgery, this needs to come from your pain management provider or your primary care physician. We will provide you with prescriptions for your pain medications per the rules set forth on your pain contract for a **maximum** of 90 days post-operatively. This does not guarantee that you will receive pain medication for 90 days. If you require pain medication beyond the allotted time frame you will be referred to back to your primary care physician or a pain management physician for ongoing pain management needs.

You understand that opioids and other controlled medications are prescribed to increase your function, activity level and quality of life. These medications may reduce your pain but may not provide complete relief. Your treatment plan will be evaluated, at least, every three months. You agree to fully communicate your pain level, functional ability and any side effects of the medication to the best of your ability. If these aspects do not improve with these medications, the risks of the medication outweigh the benefits or there is the potential of negative effects related to another medical condition or medication, your provider may reduce or eliminate the medications from your treatment plan.

You agree to inform your physician of all medications you are taking, including herbal remedies, since Opioid medications can interact with over-the-counter medications and other prescribed medications. This is especially true of cough syrup that contains alcohol, codeine or hydrocodone.

To ensure your safety, **it is your obligation and responsibility to take medications exactly as prescribed by your physician** (dose and frequency). You understand that these medications can lead to physical dependence and/or addiction, and can be associated with other risks including, but not limited to, decreased effectiveness, physical and psychological dependence, confusion, itching, difficulty urinating, constipation, allergic reactions, decreased sex drive, drowsiness, nausea or vomiting, trouble driving and/or operating machinery. Taking more opioids than prescribed or mixing sedatives, benzodiazepines, sleep medications, or alcohol with opioids can result in fatal respiratory depression.

You agree to **only take pain medications prescribed by Dr. Jacob or his covering physicians and/or partners**. Do not take any pain medication given to you by another person or provider (health, dental, clinic or emergency department) or increase your dosage without authorization from this physician. You understand that taking more medication than prescribed or taking pain medication from another source may lead to **overdose** that could result in slowed or stopped breathing, brain injury from lack of oxygen, coma, or death.

You understand that there is an increased risk of overdose associated with the use of opioids in combination with medications used to treat anxiety disorders, panic attacks, insomnia or seizures (benzodiazepines), alcohol and other central nervous system depressants. If you are prescribed these medications by another provider at any time during your pain management treatment, you must inform your physician immediately. You must also inform all other treating healthcare providers of the medications being prescribed as a part of your pain management treatment plan.

You understand this clinic has a policy of limiting dosing to a maximum of **100mg of Morphine or equivalent maximum doses as outlined in the CDC Opioid Treatment Guidelines and Oklahoma state law**. You agree to comply with such policies and dosing limitations.

You understand addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history. You understand your medications are required to last for the duration prescribed. You must safeguard and protect your prescription medications, including keeping them in a safe place and away from children. It is recommended you keep them in a locked safe or cabinet. You must not share, sell or otherwise permit others to have access to these medications. If you fail to meet this prescribed timeline, your medication is lost, misplaced, destroyed or stolen, **early prescription refills will not be permitted**. This physician reserves the right to choose to taper or discontinue medications that are lost or stolen.

If you intend to stop taking your medications, have a negative reaction, or fail to submit your prescription refill request according to the policies below, you must discuss this discontinuation of medications with your physician prior to doing so. Sudden discontinuation of medications may result in withdrawal, including nausea, shakiness, sweating, rapid heart rate, diarrhea, high blood pressure, pain or severe nervousness. If your physician discontinues your medications as a part of the treatment plan, non-compliance or dismissal from the practice, you will be provided with a weaning or tapering dose to avoid negative withdrawal effects.

All prescriptions will be obtained at **one pharmacy**, when possible. Should the need to change pharmacies arise, you must inform our office immediately.

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 doctor they see that they obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. If you see another doctor who gives you a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), you must notify your doctor. I am not to seek or accept medications from other providers without my doctor's permission, except in the event of a true medical emergency in which case, I must notify my doctor as soon as possible.

The prescribing physician and staff have permission to discuss history, diagnosis and treatment details with dispensing pharmacists or other professionals who provide you healthcare.

This clinic and/or physician retains the right to discuss your treatment with law enforcement officials during any official investigation.

You agree to read the package inserts and prescription bottle labels for any prescribed medications. You will discuss any questions or concerns regarding contraindications or reactions with your physician. You will inform this clinic, immediately, if you have a reaction or are allergic to any prescribed medication.

You will be asked to obtain a Narcan or opioid "overdose kit", available from local pharmacies without a prescription. Failure to comply may result in discontinuation of medication.

**(Female Patients Only)** To the best of your knowledge, you are NOT pregnant. You agree to use appropriate contraceptive during your course of treatment. **If you do become pregnant or suspect pregnancy, you will notify your physician IMMEDIATELY.** You understand there are potential \*risks associated with pregnancy and chronic opioid therapy. You or your unborn child may experience significant or serious side effects related to the medications you are prescribed.

**\*(Patients Currently Pregnant) The short-term use of opioids for acute pain can be safe when prescribed by your physician. Long-term use of opioids can be harmful for your unborn baby. There is also a risk of neonatal abstinence syndrome with use of opioids that can require in-hospital treatment of the baby after birth. You should discuss alternatives to opioids for pain control, but non-steroidal anti-inflammatory drugs should not be used in the third trimester of pregnancy.**

You must keep your scheduled appointments. If you are unable to make it to an appointment, please provide 24-hour notice to cancel. **If you fail to appear or give the requested notice of cancellation, your medications may not be refilled.** If you fail to appear for more than 2 appointments, you may be dismissed from our practice.

**You understand that if anytime, your provider has reason to believe that you are not in compliance with the terms of this agreement or your treatment plan, the provider may terminate this agreement and medications with a proper weaning dose. If you wish to terminate this agreement, please contact our office for guidance.**

Your health care team is dedicated to your safety and the control of your pain, and we must have your cooperation to achieve these goals. The agreement is designed to ensure your safety and to help us and you comply with the standards of good medical care, as well as, state and federal laws related to chronic opioid therapy. Please sign below.

#### **SUMMARY OF INFORMED CONSENT:**

- All prescriptions must be sent electronically per state law. No paper prescriptions will be issued.
- Pain medication will only be prescribed for a maximum of 90 days post-operatively.
- **You are not guaranteed pain medication during this time period**
- If continued pain management is needed after this time, you will be referred for further care.
- You may not share, sell, or trade my medicine.
- I agree not to take any medicine not prescribed to me.
- Forging or altering a narcotic prescription or distributing medications to others is a crime.
- 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.
- You will not increase your medicine without speaking with Dr. Jacob or one of his physician assistants.
- Your medicine will not be replaced if it is lost, stolen, or used up sooner than prescribed.
- You will keep all appointments set up by your doctor.
- You will notify your doctor's office at least 24 hours prior to your scheduled appointment if you must cancel.
- Multiple cancellations, no-shows, or rescheduled appointments is considered non-compliance and may result in dismissal.
- You will bring the pill bottles with any remaining pills of this medicine to each clinic visit if requested.
- You agree to come to the office for a pill count at any time if asked by my doctor.
- You agree that you will not use any illegal substances.
- You understand that your doctor's office will use the Oklahoma Bureau of Narcotics Drug Tracking Program as required by law.
- You have been informed by your doctor about narcotic effects, including the normal physiological effects of tolerance (where you might need to take more medication to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if you stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior).
- You understand that narcotics can adversely affect your judgment in making business decisions and in operating equipment such as an automobile.

- You understand that refills of narcotic medication will be given only during my regularly scheduled appointments or, when appropriate, by telephone if the current prescription has been correctly used.
- You will only use one pharmacy to get your medicine. Your doctor may talk with the pharmacist about your medicines.

**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.

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Patient Signature \_\_\_\_\_ Patient Printed Name \_\_\_\_\_ Date \_\_\_\_\_

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Witness Signature \_\_\_\_\_ Witness Printed Name \_\_\_\_\_ Date \_\_\_\_\_

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Dr. Paul B. Jacob \_\_\_\_\_ Date \_\_\_\_\_