Jagannathan Neurosurgery

Madison Heights West Branch Wyandotte Garden City Dearborn
Southeast Michigan Offices: 248-733-9904 Northern Michigan Offices: 989-701-2538

Physician-Patient Pain Management Agreement

Patient name_____ Date of Birth_____

I understand, accept and agree to the following terms and conditions in order to receive care for the treatment of pain at Jagannathan Neurosurgery (***Place you initial next to each statement)***

Patient Initials

_____I understand that my provider and I will work together to find the most appropriate treatment for my pain. This treatment is intended to partially relieve and not necessarily eliminate my pain. The idea behind treatment is to improve the ability to function.

_____I understand that opioids therapy maybe used to treat my pain if appropriate. However, opioids may not necessarily be the mainstay of my pain management and at times not used in my management.

_____I understand that opioids do not always alleviate pain. In fact, at times opioids can worsen pain. Thus, constant escalation of dosing of opioids is not the solution for pain management.

_____I understand that my provider and I will continually evaluate the effect of opioids on achieving treatment goals and make changes as needed. I agree to take medications at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

_____I will not seek opioid management from a second provider. I understand that regular clinic follow up is required and only my provider will prescribe these medications to me at the scheduled appointments. I understand that my provider will not mail or call in my prescriptions.

_____I will attend all appointments, treatments, and consultations as requested by my providers. I will follow pain management recommendations by my provider.

_____ I understand common adverse effects of opioids (i.e Morphine, Dilaudid, Norco, Vicoden, Fentanyl, Oxycodone, or any other pain medication) are variable from person to person and can at times be dose dependent. Side effects include but are not limited to: death, coma, altered mental status, respiratory distress, respiratory arrest, nausea, vomiting, constipations, dizziness, sweating liver failure, kidney failure, cardiac arrhythmias and others not listed here.

_____I understand that my medications have a strong likelihood of making me drowsy and affect my coordination. Thus, I agree to refrain from driving a motor vehicle or operating any dangerous machinery or climbing any heights until the drowsiness disappears. Thus, we recommended that you not drive, climb heights, operate heavy machinery or partake in any activity at home or work that requires your complete level of attention or consciousness when taking these medications.

_____I may experience medication intolerance and medication interaction with other prescribed or over the counter medications. Thus, it is my responsibility to disclose all medications for other medical necessities to my provider to better avoid potential interactions. At times these interactions are not preventable without the discontinuation of prescribed or over the counter medication.

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_____Patient is aware that prescribed pain medications can result in physical dependence and withdrawal side effects if abruptly discontinued. Furthermore, some medications can result in abuse and addiction. I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.

_____If you are pregnant or expecting to get pregnant, it is the patient responsibility to make the prescriber aware of this change. When pregnant and consuming opioids the offspring (baby) can be become opioid dependent. I will do all that is possible to avoid being pregnant unless otherwise approved by my provider.

_____I understand that if my medications are stolen or misplaced, I agree to make an immediate police report and bring a copy of the report to the prescriber to be included part of his or her medical records. Furthermore, in the event that medications are stolen, the prescriber will NOT replace the stolen medication with a second prescription. Thus, it is the responsibility of the patient to always guard his or her medications to prevent this from happening. If this re-occurs patient will be discharged from clinic.

_____I understand that using or attempting to use a forged or falsified prescription will result in the immediate discharge from the practice, and notification of the appropriate law enforcement agencies.

_____The patient is required to engage in all prescribed remedies for pain management by the physician that are not only limited to medications. These remedies maybe any of the following or others not listed below:

(1) Regular office visits to assess level of pain control.
(2) Physical therapy when determined to be beneficial.
(3) Interventions when thought to be the optimum way for pain control. This maybe surgery, medication injections or any other form of treatment that maybe offered by this office or other physician offices if determined to be necessary.
(4) Patient is aware that he or she has right to refuse treatment. Patient is also aware that the physician also has the right to refuse to provide treatment in the setting where best medical intervention is being refused by patient.

_____I am aware that there is medication monitoring policy conducted by this office that may include any or all of the following:

(1) All new patients will have a urine drug screen (UDS) at the day of the visit. Prescription for UDS will be given to patient and it is his or her responsibility to complete this order within 24 hours of the visit at local facility or same day if done in our facility and request the results faxed over to our office. If results are not received patient will not be allowed to follow up in our practice.
(2) Any patient that is using any form of illicit drugs (marijuana, cocaine, LSD, heroine, crack, mushrooms, PCP , Meth, or any other drug) will not be treated in our clinic.
    a. This holds true for all new patients and established patients.
    b. If any of these compounds are detected in the urine drug screen you will be discharged from the clinic.
(3) Patient is expected to present to clinic within one day of notice for random pill counting.
(4) My provider is allowed to obtain information from State controlled substance databases and other prescription monitoring programs during the course of my treatment.
(5) Genetic testing to determine level of metabolism maybe considered in certain situations.

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_____I understand the general medication management of this office

(1) Patient is only to accept opioids or any other form of pain medication from our office.
(2) Patient is to use the same pharmacy of his or her choosing for all medications.
(3) Patient not to alter the medication, dose or schedule of medication prescribed.
(4) Patient understands that these medications are not to be abruptly stopped. If stopped abruptly can results in side effects that can affect cardiovascular or central nervous system and even death.

_____I understand that it is my responsibility to maintain safe keeping and renewal of medications:

(1) It is the patient responsibility to store his or her mediations in a safe environment that is kept away from pets, children, elderly or any individual in which the prescription is not intended for.
(2) Patient is responsible for safe disposal of unused medications. Discuss with pharmacist for proper way of disposal.
(3) Diversion and sharing of medications is not permitted.
(4) This office will only renew the medications in person and only at the appropriate time.

_____I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when is deemed medically necessary in the provider's judgment.

_____I authorize my providers and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____I understand that my failure to meet the requirements of this agreement may rest in my provider choosing to stop writing prescriptions for me. In this case, my doctor may choose to taper my medications over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not a viable option, I understand that I maybe discharged and provided with 30 day supply of medication for use while I find a new physician to treat my pain. I understand that withdrawal from medication can be deadly and will be coordinated by my provider and may require a specialist referral.

_____I have reviewed and agree to all the terms of this contract. Also, all of my questions about this agreement have been answered by my provider.

_____ _____
Patient name (PRINT) Patient Signature and Date

_____ _____
Prescriber name (PRINT) Patient Signature and Date