Opioid (Narcotic Pain Medicine)
Maintenance Agreement

1. I understand that maintenance opioid therapy is an attempt at controlling pain for a more productive and active life. Patients on opioid therapy must maintain a current activity level through the use of opioids, or my doctor may not continue to provide me with the medication.

2. I agree to have only one physician responsible for any of my opioid prescriptions and that will be my physician at Calderon Medical Group or his designate, in my physician's absence. If I am acutely injured and require opioid medication beyond any current requirement, I will inform that treating physician that I am only to receive an emergency supply of opioids until I can be seen back in my physicians office. If I am hospitalized, my attending physician will assume my pain prescribing until I leave the hospital. In addition, I will have that physician contact my prescribing physician. If I received more than any emergency supply of pain medication when I leave the hospital, I will be in violation of this agreement.

3. I have been informed of the risk of opioid medications which include, but are not limited to side effects such as itching, skin rash, urinary retention, immune dysfunction, sexual dysfunction, sleeping difficulties, excessive sweating, and altered mental status, if opioids are over used or combined with other medications or alcohol. I could develop excessive sedation and decreased breathing or even stop breathing, which would cause certain death when taking opioid medications.

   In addition, I may experience sedation, poor decision-making ability, and impaired motor (muscle) control at times particularly if combined with any alcoholic drink or if I am taking additional medications such as muscle relaxants, anti-depressants, anti-epileptic medication to control certain types of pain or sedation medications to control anxiety. If any of these side effects occur, I understand that I should refrain from any activity, which may require alertness, such as driving, making important decisions or operating potentially dangerous devices, and I should contact this office immediately.

4. I have been explained that all opioid usage is associated with the possibility of developing tolerance to the medication, which means that increasingly high dosages of the medication may be necessary to control my pain. Also, I understand that if my condition worsens, and If I require a higher dose of opioid medication that I may be referred to a specialist in order to provide appropriate treatment and maintenance of the medications.

5. I also understand that the use of opioid medication is likely to cause the development of a dependency on the opioid medication. This means that if I stop the medication abruptly, a withdrawal syndrome will occur which will be very uncomfortable, where I will be subject to racing of my heart, elevation of my blood pressure, sweating, nervousness, abdominal cramps, diarrhea and serious mood alterations. Any of these symptoms could aggravate my other medication conditions.

   I further understand that the development of dependence does not mean that I am addicted to opioid medication. Addition means the loss of control of my medication usage a preoccupation with the acquisition of medication; compulsive usage of the medication beyond the usual and customary dosages; and continued usage of the medication in the face of psychological, physical, social, economic, or legal harm.

   I have informed my doctor of ALL medications which I am currently taking, because I understand that the opioid medications can interact with a number of medications which could cause harm to me and for that reason I will use only one pharmacy for all medications unless I inform the physician office in writing in advance.

6. I understand that opioid prescriptions require constant supervision and monitoring on a regular basis. I will bring back medications remaining from the previous appointment in its original pharmacy bottle.

7. If any of the following conditions occur, I understand that I may be subject to having my opioid medication dose tampered and discontinued:

   Acquisition of opioid drug from other doctors.
   Uncontrolled dose escalation (increases)
   Loss of prescriptions or frequent mysterious drug disappearances.
   In addition, after my pain medication is tampered and discontinued, I will cease to have patient/physician relationship with my provider in this practice no matter where the office is located.

8. I understand that if Marijuana is found positive in the urine drug test that I must present a current Marijuana card/license in order for my medications to be refilled. If I am unable to provide this, I understand that I may be discharged from the practice for failure to comply.

9. My doctor reserves the right to perform random quarterly or unannounced urine, saliva or hair toxicology tests. I will pay a fee of $35.00 to the provider office in advance for the collection and initial review of the test. My sample may then be sent to a lab for final review and that will be billed to my insurance if I have any. Any costs not covered by my insurance will be my responsibility and I may receive a bill from the outside laboratory. I further understand that my insurance will not reimburse me for this cost. If I have no insurance and my sample is sent to the outside lab for confirmation, I will also pay and additional $40.00.

10. The presence of a non-prescribed drug or the absence of prescribed drugs may be grounds for immediate termination of the doctor/patient relationship. I understand that the record of the presence of a non-prescribed substance in my body may have serious consequences later. Some of the consequences of this fact may be the denial of insurance coverage or issuance, denial of professional licensure, denial of admittance to training or educational programs or exclusion from working in certain professions or serious other consequences.

11. I waived my right of privacy so that my doctor may contract any of my health care providers, my family, the Nevada Prescription Drug Controlled Substances Task Force, law enforcement or any legal authority to obtain or provide information about me which would be used in my care and/or to protect my doctor's opioid prescribing privileges. I understand that some Federal law (HIPAA) already allow my physician to share medically relevant information to other health care providers or organizations in the ordinary course of providing my care. If I do not agree with this condition, I will notify my physician immediately, however, this may affect my ability to continue to receive my medication and I understand that I may have to find another physician to continue receiving my medication.

    The above agreement has been entered into, in consideration, for my doctor prescribing opioid (narcotic) medication to me for any ongoing treatment of my pain. I understand that other physicians may not require me to sign an agreement such as this and might at any prescribe my medication without such agreement and that I am free to seek such a physician at any time. I am signing this agreement of my own free will with that knowledge.

_____ I have received for my own records, a copy of this signed agreement.

_____ I understand this agreement including the financial aspects, and have had the opportunity to have any questions I may have answered and explained to me.

_____ _____ _____

Patient Signature Date Print Patient Name

_____ Witness