Sample Patient Agreement Forms

Introduction

This resource includes two sample patient agreement forms that can be used with patients who are beginning long-term treatment with opioid analgesics or other controlled substances. These documents contain statements to help ensure patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), the conditions under which their treatment may be terminated, and the responsibilities of the health care provider. These documents can help facilitate communication between patients and healthcare providers and resolve any questions or concerns before initiation of long-term treatment with a controlled substance.

Pain Treatment with Opioid Medications: Patient Agreement*

I,_____, understand and voluntarily agree that
(initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all on my medicines:_____
Pharmacy name/phone#

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at_____are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We

will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date

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Patient Agreement Form

Patient Name:
Medical Record Number: **Addressograph Stamp:**

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of_____(print names of medication(s)) may cause addiction and is only one part of the treatment for:_____(print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

☐ to improve my ability to work and function at home.

☐ to help my_____(print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

<u>I agree to the following:</u>

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

<u>Refills</u>

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made**. I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

<u>Pharmacy</u>

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.
The name of my pharmacy is_____.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

_____ _____

Patient's signature Date

_____

Resident Physician's signature

_____

Attending Physician's signature

- ☐ This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient's card should be sent to the medical records department and a copy given to the patient.)