Helix Pain Solutions

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Long Term Use of Controlled Substances for Treatment of Chronic Pain

The purpose of this agreement is to protect patient access to controlled substances and to protect our ability to prescribe such substances for our patients.

The long-term use of such substances as opioids, benzodiazepines, and barbiturates is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged.

For this reason the following policies are agreed upon by the below-signed patient, as consideration for, and a condition of, the willingness of a Helix Pain Solutions provider to consider the initial, and/or continued prescription of controlled substances to treat your chronic pain.

1. I will keep and be on time for all my scheduled appointments with the doctor and other members of the Helix Pain Solutions treatment team.
   Initial: _______

2. I will participate in all other types of treatment that I am asked to participate in by the treatment team and providers at Helix Pain Solutions.
   Initial: _______

3. All controlled substances must come from a Helix Pain Solutions provider unless specific authorization is obtained for an exception. Multiple sources can lead to untoward drug interactions or poor coordination of treatment.
   Initial: _______

4. All controlled substances must be obtained at the same pharmacy, whenever possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that I have selected is:

Pharmacy	**Telephone Number**

5. I understand, I am expected to inform the front office of Helix Pain Solutions within a week of any new medications or medical conditions, and of any adverse effects I experience from any of the medication that I take.
   Initial: _______

6. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.
   Initial: _______

7. I will not use any illegal substances, including marijuana, methamphetamines, cocaine, etc. I will not share, sell, or trade my medications with anyone. I will not attempt to obtain any controlled medicines, including opioid pain

medicines, controlled stimulants, or anti-anxiety medicines from any other doctors without prior notification and approval by a Helix Pain Solutions physician.
Initial: _______

8. I will make sure I have an appointment for refills of controlled medications. If I am having trouble making an appointment or if unforeseen circumstances occur, then I will tell a member of the treatment team immediately.
Initial: _______

9. I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit. No refills will be available during evenings or on weekends. Renewals are contingent upon keeping scheduled appointments.
Initial: _______

10. I understand that these drugs should not be stopped abruptly, as an abstinence syndrome or withdrawal symptoms will likely develop.
Initial: _______

11. I understand I am required to cooperate with all unannounced and/or routine urine, saliva or serum toxicology screens that are requested by Helix Pain Solutions providers. Presence of unauthorized substances may prompt referral for assessment for addictive disorder and discontinuation of care by Helix Pain Solutions management.
Initial: _______

12. Original containers of medications will be brought in to each office visit and pill counts will be performed.
Initial: _______

13. I agree to obtain and store opioid antagonist medications (e.g. Naloxone, Narcan, Evzio) to be used in the case of an emergency or in an overdose situation.
Initial: _______

14. I agree to have an individual other than myself (e.g. spouse, child, caregiver) be trained in the use of emergency opioid antagonist medications.
Initial: _______

15. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially children, I understand the importance of keeping them out of reach of such people.
Initial: _______

16. Medications may not be replaced if they are lost, get wet or are destroyed, etc. If medication is stolen, I understand a police report must be filed and provided to Helix Pain Solutions for an exception to be considered.
Initial: _______

17. Prescriptions may be issued early if the provider or patient will be out of town when a refill is due, at the discretion of the Helix Pain Solutions providers. These prescriptions will contain instructions to the pharmacist that they should not be filled until the appropriate date.

Initial: _______

18. I waive my right to confidentiality, specific to my controlled substance prescriptions and administration, if Helix Pain Solutions staff is approached by law enforcement authorities.
    Initial: _______

19. I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to the staff or disrupt the care of other patients, then my treatment will be stopped and options for transfer of care will be made available.
    Initial: _______

20. I will keep up to date with any bills for treatment and will tell the staff of Helix Pain Solutions immediately if paying for treatment becomes an issue.
    Initial: _______

21. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by Helix Pain Solutions providers or referral for further specialty assessment.
    Initial: _______

22. I understand that all medical treatment is initially a trial, and that continued prescription is contingent upon evidence of benefit.
    Initial: _______

23. I understand the risks and potential benefits of these therapies.
    Initial: _______

By signing below, I affirm that I have read this agreement and understand and agree to all the terms as stated above.

Provider Signature	Date
Patient Signature	Date

Mission Statement of Helix Pain Solutions

We, here at Helix Pain Solutions, are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

1. 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.

2. We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having adverse reactions to the medications prescribed.

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

4. 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.

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

6. 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.

7. If you become addicted to these medications, we will help you get treatment and get off the medications that are causing you problems safely by referring you to providers capable of providing such treatment.

By signing below, I affirm that I have read this agreement and understand and agree to all the terms as stated above.

Provider Signature	Date
Patient Signature	Date