

# CONSENT FOR PAIN MEDICINE PRESCRIPTIONS

Please confirm that you agree with the following statements by **initialing** each one.

- \_\_\_ 1. I am not currently abusing illicit or prescription drugs, and I am not undergoing treatment for substance dependence or abuse.
- \_\_\_ 2. I have never been involved in the sale diversion or transport of controlled substances.
- \_\_\_ 3. I authorize the release of medical records from all previous physicians, including psychological reports to Pain Mgmt Assoc.
- \_\_\_ 4. I give my permission to allow Dr. Bosscher and staff to discuss fully all diagnostic and treatment details with my previous and present physicians, pharmacies, and insurance carriers.
- \_\_\_ 5. I authorize the doctor and pharmacy to cooperate fully with any city, state or federal law enforcement agency, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize the doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or confidentiality with respect to these authorizations.
- \_\_\_ 6. I will only use **ONE** pharmacy for filling pain medicine prescriptions. Pharmacy \_\_\_\_\_
- \_\_\_ 7. I will reveal all medications that I am taking.
- \_\_\_ 8. I will **NOT** request or accept pain medication from any other physician or individual. (*Hospital inpatients do not apply.*)
- \_\_\_ 9. I agree to take my pain medications **ONLY** as prescribed by Dr. Bosscher.
- \_\_\_ 10. I will **NOT** stop taking medication on my own without medical advice and I agree to follow the advice of Dr. Bosscher regarding the stopping of a controlled substance.
- \_\_\_ 11. I agree to keep track of the amount of medication remaining and schedule appointments for refills with the following conditions:
  - a. Prescriptions will only be given to the patient for whom the medication is prescribed.
  - b. Appointments will be scheduled during regular office hours, 8:30am to 4:30pm, Mon. thru Thur. and, 8:30am to 12:00 noon on Fri. Refills will **NOT** be made at night, on holidays, weekends, or Fri. afternoon because, "I just realized I will run out."
  - c. Refill appointments must be scheduled 48 hours in advance.
  - d. Every third month you must be seen by the physician. (**No exceptions**) *Dr. Bosscher's schedule fills up quickly, so it is best to schedule these appointments as early as possible.*
- \_\_\_ 12. I understand that early refills will not be given.
  - a. **NO** allowances will be made for lost prescriptions, medications that are spilled or misplaced or any other reason.
  - b. Keep all medications in a safe place, especially away from children. They may be hazardous or lethal should they be inadvertently taken by any person other than who they were prescribed for.
  - c. If you use up your medication before the scheduled refill date, the remaining days will be endured with no medication.
- \_\_\_ 13. If I should need a prescription change prior to my scheduled refill date, I agree to bring all unused medication to the office prior to receiving the new prescription.
- \_\_\_ 14. I understand Dr. Bosscher reserves the right to order random urine drug screens and I will comply with such request.
- \_\_\_ 15. (FEMALES ONLY) I certify that I am not pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them.
- \_\_\_ 16. (MALE ONLY) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
- \_\_\_ 17. I agree to accept full responsibility for the risks taken, secondary to my consent of narcotic consumption for the management of my pain, which include but are not limited to drug dependence, tolerance, and/or addiction.
- \_\_\_ 18. I understand that Dr. Bosscher reserves the right to dismiss me from care should any violations of the above occur.
- \_\_\_ 19. I understand that Dr. Bosscher will report any illegal activities, such as script altering, buying or selling of medication, or doctor shopping, to the proper authorities.

Evidence of medication hoarding, increasing use of medication without communication to the pain clinic staff, hostile behavior toward our staff, refilling prescriptions too frequently, getting medication from multiple physicians or pharmacies, increasing amounts of medications, altering prescriptions, selling medication, unapproved use of other drugs (alcohol, sedatives, or street or "illicit" drugs) during narcotic analgesic treatment or other unacceptable behavior will result in dismissal from the clinic.

I have read this entire agreement and have had the opportunity to ask questions. All of my questions have been answered satisfactorily. I consent to the use of pain medication under the terms outlined in the agreements. I will be given a copy of this policy for my reference.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Witness \_\_\_\_\_

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