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Controlled Substance Agreement Informed Consent Form

The following agreement relates to my use of controlled substances for chronic pain prescribed by a physician at the Athens Spine Center. I recognize that there are policies regarding the use of controlled substances which are followed by the staff at Athens Spine Center. I will be provided controlled substances while actively participating in this program only if I adhere to the following regulations:

- I will use the substances only within the parameters given by the Athens Spine Center physician. I will **NOT** increase my opioid usage or abruptly stop my opioid usage without authorization from the Athens Spine Center physician.
- I will **NOT** receive replacement medications for “lost” or “stolen” medications.
- I will receive controlled substances **ONLY** from Athens Spine Center. Information that I have been receiving controlled substances prescribed outside Athens Spine Center will lead to a discontinuation of treatment.
- I will **NOT** expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out.
- I will accept generic brands of prescription medication.
- I understand that opioids can impair motor skills. Caution is urged when driving a vehicle or operating equipment.
- I will notify Athens Spine Center if I am considering pregnancy or become pregnant.
- If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as prescribed by the physician. I will not hold any member of Athens Spine Center liable for problems caused by discontinuance of controlled substances, provided that I receive 30 days notice of termination.
- I agree to submit to urine and blood screens to detect the use of both prescribed and non-prescribed medications at any time.
- **I understand that if illegal substances or undisclosed prescribed medications not approved by the physicians of Athens Spine Center are detected in the urine or blood screen I may not be accepted as a new patient or may be terminated as an existing patient of Athens Spine Center.**
- **I understand and authorize Athens Spine Center to disclose, request and/or use information concerning my medical history (INCLUDING MEDICATION HISTORY) from pharmacies, insurance companies, healthcare operations, and/or other physicians. This authorization will be effective as long as I am a patient of Athens Spine Center and will be revoked upon termination as a patient of Athens Spine Center.**
- I understand that if I miss two appointments, I may be discharged from the care/management of Athens Spine Center.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects in the Pain Management Program to secure increased functioning and improved coping with my condition.

Patient or Guardian (with defined relationship) Signature**

Date

Witness

Date

Physician's Signature

Date

**Must be signed in presence of witness