

A.A. Specialty Health Center
Pain Management Agreement
www.aapain.com

I, _____ understand that in order to receive care for the treatment of pain at A.A. Pain Clinic, Inc., I agree to comply with the following:

- A. **USE OF MEDICATIONS:** I will take all medications as prescribed. I will speak with a provider at A.A. Pain Clinic, Inc. before making any change in either the dose or frequency of my medications. There will be no early refills of pain medications without prior authorizations. Narcotic pain medications must all be obtained for the same pharmacy (any exceptions must be approved by A.A. Pain Clinic).
- B. **SEEKING PRESCRIPTIONS:** I will neither seek nor fill prescriptions for any medications related to pain relief from any other health care provider unless authorized by A.A. Pain Clinic, Inc.
- C. **MEDICAL RECORDS RELEASE:** I will inform all of my health care providers that I receive pain management through A.A. Pain Clinic, Inc. and will maintain an unrestricted and current medical records release on file with A.A. Pain Clinic. I authorize A.A. Pain Clinic to provide a copy of the Pain Contract to release medical information to necessary pharmacies.
- D. **MENTAL HEALTH:** A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the healthcare providers of A.A. Pain Clinic, Inc.
- E. **DRUG SCREENING:** I will participate in drug screening as a part of my treatment plan. I understand that drug screening will be conducted at least every 12 months and may be required more frequently at the discretion of A.A. Pain Clinic, Inc. Screening may include urinalysis, blood testing and/or pill counts. I agree to pay any and all cost associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of service.
- F. **ILLEGAL AND NON-PRESCRIBED DRUG USE:** I understand that the use of any controlled medication, not prescribed by A.A. Pain Clinic, may result in termination of care. I authorize A.A. Pain Clinic to cooperate fully with any city, state, or federal law enforcement agency. I agree to waive any applicable privileged, right of privacy, or confidentiality with respect to these authorities. I also understand that the use of any illegal substance including marijuana will result in terminations of care by A.A. Pain Clinic.
- G. **LOST OR STOLEN MEDICATION:** I agree to safeguard all medication prescribed by A.A. Pain Clinic and understand that lost or damaged medications will not be replaced.
- H. **PRESCRIPTIONS WHILE TRAVELING:** A.A. Pain Clinic, Inc. may provide prescriptions for up to 60 days when I am traveling out of state. I will only be eligible for early medication when proof of travel can be obtained. Identification includes paper ticket and electronic confirmation sheet that shows how much I paid. I will have to arrange for shipment of controlled substances by my pharmacy at my own expense. If I will be out of state longer than 60 days, I need to arrange for my health care at my travel destination. On return to Anchorage, I need to advise A.A. Pain Clinic of the name and address of my provider out of state. I also authorize A.A. Pain Clinic to contact my provider to obtain any detailed information deemed necessary in my medical care.

- I. **DRIVING AND OPERATING EQUIPMENT:** Many pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.
- J. **MISSED APPOINTMENTS:** Please contact the clinic if you will be 5 to 10 minutes late. If I arrive later than 15min, I will be rescheduled. Three missed appointments per year are grounds for termination from AA Pain Clinic.
- K. **CANCELLATIONS:** As of **September 1, 2008**; we require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or rescheduled without a 24 hour notice will result in a **\$50.00** fee to the patient.
- L. **TERMINATION:** I will no longer be eligible for care at A.A. Pain Clinic if I am in possession of illicit drugs or substance, trafficking in controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in anyway, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at A.A. Pain Clinic
- M. **TREATMENT OF STAFF:** Our clinic has a zero tolerance policy for verbal abuse towards our staff. Swearing, yelling at, or threatening of our staff will result in termination from our clinic.
- N. **EMERGENCY ROOM VISITS:** I am allowed to receive pain medication in the emergency room, but it is a violation of the A.A. Pain Clinic contract to receive narcotic medication to take home and must be discussed with the on-call doctor prior to receiving medication. A violation includes any prescription and/or samples.

Have you ever had any medical or legal problems with alcoholism, drug abuse (including marijuana), addiction or drug trafficking? If yes, please explain:

Have you used any illegal drugs (including marijuana) within the past six months? If yes, list the drugs you have used and when:

Have you used any prescription drugs for which you did not have a personal prescription within the past six months? If yes, please explain:

I HAVE THOROUGHLY READ THIS AGREEMENT BEFORE RECEIVING TREATMENT AT A.A. PAIN CLINIC, INC. I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED. I KNOW THAT FAILURE TO COMPLY WITH ANY OF THESE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATIONS OF SERVICE.

Reviewed contract and answered all patients' questions (MA): _____ Date: _____

Patients' Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____