Peninsula Spine and Pain Clinic
Pain Management Agreement
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I, _____ understand that in order to receive care for the treatment of pain at Peninsula Spine & Pain Clinic (PSPC), I agree to comply with the following:

A. **USE OF MEDICATIONS**: I will take all medications as prescribed. Opioid pain medications must all be obtained from the same pharmacy and in the State of Alaska only.

   A1. PSPC recognizes the CDC recommendations on opioid prescription levels. Patients that are over 90 Morphine Equivalents will be actively tapered to 90 MMEs OR LESS. New patients to PSPC will not receive prescriptions over a 90 MME level. **(If you need clarification on how MMEs are calculated discuss this with your provider).**
   A2. Patients are required to be established with a primary family doctor. PSPC will not prescribe primary care medications such as Lipitor, Crestor, Ambien, Xanax, etc.
   A3. Patients on behavioral health medications such as Adderall, Ritalin, etc. PSPC will not prescribe behavioral health medications.

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 PSPC.
C. **EMERGENCY ROOM VISITS:** I am allowed to receive pain medication in the emergency room, but it is a violation of the PSPC contract to receive narcotic medication to take home and it must be discussed with the on-call doctor prior to receiving medication. A violation includes any prescription and/or samples.
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 PSPC.
E. **DRUG SCREENING**: I will participate in drug screening as a part of my treatment plan. I understand that drug screening will be conducted routinely. Screening may include urinalysis, blood testing and/or pill counts. I agree to pay any and all costs 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. **ALCOHOL USE:** Any use of alcohol with prescriptions is against clinic policy. Testing for alcohol use may be added to random and routine urine drug screens at the discretion of the physician. Any use of alcohol deemed inappropriate by the physician will be grounds for termination from PSPC.
G. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that use of any controlled medication, not prescribed by PSPC, may result in termination of care. I authorize PSPC 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 may result in termination of care by PSPC.
H. **LOST OR STOLEN MEDICATION**: I agree to safeguard all medication prescribed by PSPC and understand that **LOST, STOLEN, OR DAMAGED MEDICATIONS WILL NOT BE REPLACED.**
I. **PRESCRIPTIONS WHILE TRAVELING**: Prescriptions must be filled in the State of Alaska prior to travel out of state. Prescriptions will not be filled early. PSPC does

not permit prescriptions to be filled in other States. If traveling more than 30 days, patients will need to get established with another pain provider in the State of travel.

J. **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 while under the influence of any prescribed medication.

K. **MISSED APPOINTMENTS**: I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. Three missed appointments per year are grounds for termination from PSPC.

L. **CANCELLATIONS:** 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. Procedure cancellation or no show fees are **$100.00**.

M. **CHARGES:** All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from PSPC.

N. **TERMINATION**: I will no longer be eligible for care at PSPC if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at PSPC.

O. **TREATMENT OF STAFF**: Our clinic has a zero tolerance policy for verbal abuse towards our staff. Swearing, yelling at, or threatening our staff will result in termination from our clinic.

P. **MEDICAL RECORDS RELEASE:** I will authorize PSPC to obtain my medical records from all providers I have received pain management through. I will maintain an unrestricted and current medical records release on file with PSPC.

Have you ever had any medical or legal problems with alcoholism, drug abuse, 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 PSPC 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 COMLPY WITH ANY OF THESE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATIONS OF SERVICE.

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

Patient's Signature: _____Date: _____

Practitioner Signature: _____Date: _____