OKLAHOMA PAIN CENTER

Physician/Patient Treatment and Medication Agreement

I, **_____(Print)**, have agreed to take as prescribed the following medications as part of my treatment for chronic pain. I understand that these medications may not eliminate my pain but are prescribed by my physician to reduce my daily pain in order to improve my level of activity and overall quality of life. At any given time, only one physician is allowed to prescribe me medication for the treatment of pain. My physician will make every attempt to prescribe my pain medication in a safe and responsible fashion. I understand that unintentional overdose from pain medication is a problem of epidemic proportion in our country as well as worldwide. I understand that underlying health problems such as a heart or lung condition, obstructive sleep apnea, obesity, psychiatric conditions or an unanticipated infection like pneumonia can place me at higher risk for unintentional overdose. I understand that I am at increased risk for serious, potentially life-threatening infection because of pain medication such as pneumonia especially if I also take other immunosuppression medication for conditions like rheumatoid arthritis or Crohn's disease. I understand that most medications used to treat pain cause or accelerate dental decay and can place me at risk for falls or car accidents. I agree that by reading and signing this treatment agreement that I will not hold my physician responsible for an unforeseen unintentional medication overdose or accident caused as a result of taking prescribed medications. I understand that there is a risk of addiction to pain medications which can be a devastating disease.

Pain Medications ONLY

_____ _____ _____

_____ _____ _____

_____ _____ _____

I understand the following guidelines for pain management treatment under the care of Dr. S. Blake Kelly and Dr. James E Lynch.

1) I understand that I have the following responsibilities:
   a) I will take medications at the dose and frequency prescribed.
   b) I will not increase the dosage of my medications without the approval of my physician. However, the patient can always decrease the dose or discontinue the medication if side-effects occur. Don't throw the medication away until this situation is discussed with the doctor.
   c) I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
   d) Excluding treatment at a hospital, I will not request any pain medications from other providers while under the care of my pain physician and will inform this provider of all other medications I am taking.
   e) I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In event of an emergency, I will provide this same information to emergency department providers.

Patient Signature _____

S. Blake Kelly, MD ● James Lynch, MD ● Nathan Overbey, MD
Karie Stewart, APRN ● Stacy Torres, APRN ● Angela Quick, APRN ● Jennifer McReynolds, PA-C ● Matthew Munda, APRN ● Meredith Pruitt, PA-C ● Cody McBride, APRN
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f) I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be continued or replaced. **In most instances, patients will be dismissed from Oklahoma Pain Center if pain prescriptions are reported stolen. When a medication is stolen, a major red flag is raised that the patient is noncompliant with treatment or associates closely with people that abuse prescription medications.**
g) I will keep medications only for my own use and will not share them with others. I will keep all medications locked in a safe and away from children.
h) I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.
i) I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities as directed by my doctor.

2) I will not use alcohol, illegal or street drugs, or another person's prescriptions. If I have an existing addiction problem or develop one while under the care of my treating physician, I agree to inform my doctor and seek treatment.
   Such treatment programs may include:
   a) 12-step program and securing a sponsor
   b) Individual counseling
   c) Inpatient or outpatient treatment

3) I will do my best to keep my scheduled appointments. If I need to cancel my appointment, I will do so in advance if possible and understand that I will be charged a fee if I forget an appointment or do not notify my doctor's office at least 1 business day prior to the date of my appointment.

4) I understand that if my medications are adjusted, I may not be safe to drive as impairment can be present without me being aware. I will take all precautions necessary to ensure I do not put myself or others at risk during driving or other activities. I agree to drive only if fully alert and feeling clear minded without grogginess.

5) If I am prescribed a sleep medication, I agree to be in sleep position at the time the medication is taken as serious problems can occur by sleeping in poor anatomical positions for prolonged periods of time.

6) I understand that this provider may stop prescribing the certain medications listed if:
   a) I do not show any improvement in pain or my activity has not improved.
   b) I develop rapid tolerance or loss of improvement from the treatment.
   c) I develop significant side effects from the medication.
   d) My behavior is inconsistent with the responsibilities outlined above. Any of the above may result in dismissal of care.

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7) I understand that pain *management* under the supervision and direction of my doctor is prescribed in an appropriately aggressive fashion in order to provide the most improvement in my quality of life, trying to avoid as many side-effects possible, and with the least addictive medication regimen. Buprenorphine as well as certain other medications if appropriate are prescribed in an attempt to stabilize my nervous system to keep the addictiveness of certain medications I may take to a minimum. I understand that medications prescribed for chronic pain and treatment of psychiatric conditions, however, could lead to an unforeseen addiction or cause a serious long term medical condition. ***I recognize that there are standards of medical care that are to be followed by physicians. In order to maximize my pain control and quality of life, my physician may prescribe certain medications that are used "off label" or are not approved by the FDA for the treatment of my condition. I have the right to stop them immediately of course or to seek emergency treatment should side-effects occur.*** I will not hold my physician responsible for any medication side-effects, behaviors, or problems that result from medications prescribed or treatments received in this pursuit of a more active lifestyle with improved pain control.

8) I understand that I will be required to perform periodic urine drug testing to monitor for compliance and/or periodic prescription pill counts. The majority of insurances cover urine drug testing, but I understand that I am still financially responsible if this service is not covered. I understand these services are necessary due to the scrutiny placed on pain management practices by the medical board and federal and state agencies. A medication agreement, signed yearly, urine drug testing, random pill counts and monthly office visits are simply tools to document patient compliance with a strategic pain management regimen. Random pill counts and urine drug testing do not reflect a mistrust, suspicion, or discrimination toward a patient. I understand that I have a duty to notify my doctor of medication side-effects, addictive cravings, or any problems associated with the care received from this office.

9) It is the patient's responsibility to not drive or operate machinery when any adjustment to the medication regimen is made as they could be placed at risk for an accident. In general, it is recommended that patients no drive or operate heavy machinery while taking controlled substances.

10) I understand that this is a video monitored facility. Access to this monitoring system is highly restricted for patient confidentiality. It will only be accessed by a specified protocol that is in place.

Patient Signature: _____ Date: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____]

Home Phone: _____ Cell Phone: _____

Physician: _____ Date: _____

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, **_____(Print)**, hereby assign and convey directly to Oklahoma Pain Center, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Oklahoma Pain Center, regardless of its managed care network participation status. I understand I am financially responsible for all charges regardless of any application insurance or benefit payments. I hereby authorized Oklahoma Pain Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Oklahoma Pain Center any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care facility or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Oklahoma Pain Center any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I received from Oklahoma Pain Center (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Oklahoma Pain Center all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care facility, including arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative Oklahoma Pain Center is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose an action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Oklahoma Pain Center as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Signature Date

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