



INTERVENTIONAL PAIN INSTITUTE

Diagnosis & Treatment of Spine, Cancer and Chronic Pain

Controlled Substance Agreement

This agreement is about using controlled substances for chronic pain prescribed by Dr. Barrett Johnston at Interventional Pain Institute.

If Dr. Johnston believes opioids or other controlled substances can help you, he may require psychiatric testing and/or urine toxicology testing before he decides to prescribe them. The treatment goal is not 100% pain relief, the treatment goal is meaningful pain relief that results in improvements in function. If your pain cannot be stabilized on medications, controlled substances may be stopped.

I, _____ (print name), understand that I will be provided controlled substances while actively participating in my treatment only if I adhere to the following conditions: **(Initial each statement after reviewing)**

_____ I will use the prescribed medications only as directed by my Interventional Pain Institute doctor.

_____ I will receive opioid pain medications only from my doctor at Interventional Pain Institute. Information that I have received opioid medication from **any** other sources may lead to the end of my treatment.

_____ I will keep this medicine safe, secure and out of the reach of children.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment may be stopped.

_____ If the medication is lost or stolen, I understand it will not be replaced until it is due to be refilled, and may not be replaced at all.

_____ I will not expect to receive additional medication before my next scheduled refill, even if my prescription runs out.

_____ I agree to submit to urine, blood, or saliva screens to detect the use of the prescribed or non-prescribed medications (including "street" drugs) at any time.

_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____ I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information to reach me, and that any missed tests may lead to my treatment being stopped.

_____ If it appears to the doctor that there are no benefits to my daily function or quality of life from the controlled substances, I will gradually taper my medications as directed by my prescribing doctor.

_____ I recognize that my chronic pain represents a complex problem which may get better from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my active participation in the



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management of my pain is extremely important. I agree to actively participate in all aspects of my doctors' treatment plan to maximize functioning and improve coping with my condition.

_____ I agree to schedule and keep follow up appointments with my Interventional Pain Institute doctor as recommended. I understand that failure to keep appointments may lead to the ending of treatment.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment may be stopped.

_____ I will accept generic brands of my prescription medication.

_____ I agree to use a Louisiana pharmacy for filling all my prescriptions except in case of an emergency.

_____ I am responsible for keeping track of the amount of medication I have left and to plan ahead for arranging the refill of my medications in a timely manner, so I will not run out of medications.

_____ If I violate any of the above conditions, my obtaining prescriptions and/or treatment from Interventional Pain Institute may be terminated.

_____ If I have violated this agreement by obtaining controlled substances or any prescription from another individual, or if I engage in any illegal activity (such as altering a prescription) I understand that the incident may be reported. The incident may be reported to other physicians caring for me, local medical facilities, pharmacies, and authorities such as the local police department and Drug Enforcement Agency, etc. as deemed appropriate for the situation.

Medication Refill Information:

- Advance notice of 3 business days is required for prescription refills
- Requests for refills should be telephoned or faxed from your pharmacy. Refill requests will NOT be addressed at night, on holidays, or on weekends.
- Most controlled substances required a written prescription and cannot be called into the pharmacy. You must plan to pick up your prescription during normal business hours or allow time for the US Postal Service to get your prescription to you.

This agreement will supersede all other previous agreements.

By signing below, I indicate that I understand and agree to all the terms of the above agreement.

Patient Signature

Date

Physician Signature

Date