7617 Kennedy Blvd
North Bergen, NJ 07047
Office: (201)-854-1500
Fax: (201)-854-1505

Patient Provider Agreement

I,_____,(*patient receiving chronic pain medications),*agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain and to use said medications only as prescribed. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day.

I understand that Lauren De Lucia, APN, will be my pain management provider and the only provider who will be ordering medications for my chronic pain. ***Please place your initials in the blank spaces below****.*

I understand that I have the following responsibilities (initial each item you agree to):

_____I will keep (and be on time for) all my scheduled appointments with the my pain management provider.

____Opioids are being prescribed to make my pain tolerable but may not cause it to disappear entirely. If the goal is not reached, my provider may end the trial.

____ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to me or others.

____There is a risk that opioid addiction can occur. Almost always, this occurs in patients with a family history of other drug or alcohol abuse. If it appears that I may be developing addiction, my provider may determine to end the trial

_____I will only take medications at the amount and frequency prescribed.

_____I will not increase or change how I take my medications without the approval of my pain management provider.

_____I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours. I will make the necessary arrangements before holidays and weekends.

_____I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

_____I will allow my pain management provider to provide a copy of this agreement to my pharmacy.

_____I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.

_____I understand that other providers should not change the doses of my pain medications made by current provider.

_____I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.

_____In event of an emergency, I will give this same information to emergency department providers.

_____I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.

_____I will inform my pain management provider of any new medications or medical conditions.

_____I will protect my prescriptions and medications and store them appropriately as discussed with my provider. I understand that lost or misplaced prescriptions will not be replaced.

_____I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

____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 in order to reach me, and that any missed tests will be considered positive deviation from plan of care and office regulations.

_____I must take a drug test as often and: **Randomly as per provider's request**

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

_____If I fail a drug test, I will take the drug test more often at (frequency of) the discretion of my provider.

_____If I fail a drug test, I will be referred to the Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (http://maa.dshs.wa.gov/PRR)

_____If I sell my narcotics, my name will be referred to the DSHS fraud unit.

____ I agree to attend and participate fully in any other assessment of pain treatment programs which may be recommended by the prescriber at any time.

____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 will be stopped.

____I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

FEMALES ONLY FOR THE NEXT STATEMENT:
____I understand that if there is a chance that I am pregnant I will notify the provider immediately as I take full responsibility knowing that while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life threatening for a baby.

_____If I fail all of the above, I will be discharged from your care with no notice.
Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

Pain Treatment Program Statement

We here at De Lucia Advance Practice, LLC, are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that: We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment. We will discuss regularly at your appointments to make sure you are not having bad side effects or adverse reactions. We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well. We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals. We will work with any other providers you are seeing so that they can treat you safely and effectively. We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for. If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

Pharmacy:_____ Phone Number:_____

Patient Signature: _____ Date:_____

Provider Signature: _____ Date:_____