HENDRICKSON AND HUNT
Pain Management Physicians

Jay A. Hendrickson, M.D.
Brian Kelly Hunt, M.D.

2575 E. Bidwell Street, Suite 230, Folsom, CA 95630
Phone: (916) 984-3899 Fax: (916) 984-6522

OPIOID AGREEMENT

1. You will be participating in a structured opioid therapy program for the treatment of your chronic pain. Your treatment plan will be under the direction of Hendrickson & Hunt Pain Management Physicians.
2. Medication(s) are to be used only as prescribed. If you believe that your condition has changed, then you should call Hendrickson & Hunt Pain Management Physicians during regular business hours and schedule a re-evaluation. Medication changes will not be made over the telephone.
3. Only Dr. Hendrickson, Dr. Hunt, and their associates will write the prescriptions.
4. One pharmacy will fill all the prescriptions. **LIST YOUR PHARMACY**: _____.
5. The primary goal of any treatment plan is to increase function and secondarily to decrease pain.
6. It may require several weeks to achieve a stable dosage schedule without intolerable side effects. During this period, frequent adjustments in dosage and formulation may be required. This trial may require several weeks during which periodic checks of functional progress will be made. At the end of this time a decision will be made, based upon your response to your treatment plan, to continue with the extended pharmacological therapy or to revise your current treatment plan.
7. Hendrickson & Hunt Pain Management Physicians may request blood levels of certain medications. Failure to comply may be grounds for termination of care at Hendrickson & Hunt Pain Management Physicians.
8. Evidence of abuse such as losing medication(s) or prescription(s) or obtaining medication(s) from other sources shall be considered cause for discontinuation of treatment at Hendrickson & Hunt Pain Management Physicians. In addition, the other rules that will be followed are:
    - **Lost/stolen medications will not be replaced.**
    - **Only the patient and no one else will use the medications prescribed by Hendrickson & Hunt Pain Management Physicians.**
    - **There will be random calls to pharmacies to confirm that the patient is not receiving controlled medications from other sources.**
    - **Refills will only be addressed during regular office hours. There will be no refills on evenings or weekends. Your medication(s) will only be refilled as scheduled.**
    - **If you do not have a follow-up appointment on or before your refill due date, please call the office 72 hours prior to your refill due date. If you do not call within 72 hours, your refill may be delayed.**
9. You will be seen at Hendrickson & Hunt Pain Management Physicians at periodic intervals for follow-up/ monitoring of your maintenance program. Your prescriptions will be written to approximate these intervals.
10. In the event that the decision to discontinue treatment is made, for any reason, you will be prescribed a titrating dose of medication and you will be advised to seek alternative care.
11. The purpose of this agreement is to prevent any misunderstanding and to protect the patient and the physician from those enforcing the law. If the patient breaks the agreement, it is illegal for Dr. Hendrickson or Dr. Hunt to continue to prescribe these medications. This will be grounds for termination of treatment at Hendrickson & Hunt Pain Management Physicians.

_____ _____
Patient's Signature Date

_____

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OPIOID CONSENT

I understand that the common side effects of opioid therapy include nausea, constipation, sweating, itching, dry mouth and rash. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

I understand that there is a small risk that I may become addicted to the opioid I am being prescribed. As such, my physician may require that I have additional tests and/or see a specialist in addiction, should a concern about addiction arise during my treatment.

I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens) can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all these substances without first discussing it with my physicians. I also understand that I may be discharged from care if I use any of these substances.

I agree to be responsible for the secure storage of my medications at all times. I agree not to provide my prescribed medication to any other person at the result in being discharged as a patient. I also understand that lost or stolen medications will not be refilled until the proper due date.

If I break this agreement, my physician reserves the right to stop prescribing opioid medications for me and may discharge me from care.

I hereby agree that my physician has the authority to disclose the prescribing information in my patient file to other health care professionals when it is deemed medically necessary in the physician's judgment.

Patient's Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____