

THE DOLEYS CLINIC

Medical Clinic Agreement

1. The medical clinic will only provide treatment and medications for chronic pain and select pain-related issues. I should consult my primary care doctor for all other medical issues.
2. I will take my medications exactly as they are prescribed by the doctor. Any adjustments must be approved by the doctor. I understand that the doctor will not provide additional medications if I run out ahead of schedule.
3. I will avoid alcohol and all illegal substances.
4. If I feel tired or mentally “foggy”, I will not drive, operate heavy equipment, or service in any capacity related to public safety. I understand this symptom is likely to occur during medicine dosage adjustments.
5. I will submit a urine drug screen upon my doctor’s request. My doctor might ask that a clinic staff member observe me providing the appropriate specimen. If my drug screen indicates that I am not following the guidelines of the clinic, I will see the clinic director regardless of insurance coverage. I also may be required to seek evaluation and/or counseling at a facility specializing in drug addiction/chemical dependence.
6. I will allow my doctor to contact family members and other physicians I am seeing in an effort to monitor my progress.
7. I understand the doctor will not be available to prescribe medication during evenings or weekends. My doctor’s partners will not provide me with refills by phone. It is my responsibility to call my doctor at least three (3) business days in advance of running out of medications if my appointment gets changed.
8. I will not receive medications (opioids, sleeping pills, tranquilizers, stimulants, etc.) from anyone besides my clinic pain management doctor without authorization. If I have an emergency that may require additional pain medicine, I will call my doctor’s office first if possible. I will alert the doctor at the emergency room or hospital of this agreement with the Doleys Clinic.
9. I will not share, sell or trade my medication with anyone.
10. I will safeguard my pain medicine from loss of theft by keeping them in a locked and secure location. If my pain medicines are stolen, I will immediately file a police report. I understand that lost or stolen medicines may not be replaced.
11. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including Alabama’s Board of Pharmacy, in the investigation of any possible misuse, prescription forgery, sale, or other diversion of my pain medicine. I understand that illegal substance use may be reported to the proper authorities. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
12. I will inform my doctor of any changes in any other medicine I am receiving from other physicians.
13. I will allow my doctor to receive information from any pharmacy I have used as well as the Alabama Department of Public Health controlled prescription monitoring program.
14. I will have all of my medications filled at the pharmacy I have listed. I will notify my doctor of any pharmacy changes.
15. Pain medications will be continued as long as there is (a) acceptable improvement in pain level, (b) reported increase in activities, (c) no inappropriate drug behavior, and (d) no significant, unmanageable side effects.

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16. If it is determined that pain is out of control, I will agree to be hospitalized. In this case, medications and therapies will be provided in a controlled fashion.
17. I understand that I must call at least 24 hours prior to my appointment if I need to cancel to avoid a cancellation fee.
18. For women: I will do everything I can to avoid getting pregnant while taking these medicines unless otherwise approved by my doctor. To the best of my knowledge, I am not pregnant at this time.
19. For drug administration system patients: I understand the importance of keeping my scheduled pump refill appointments. I understand if I miss my scheduled refill appointment, I may run out of medicine and go through withdrawal. I understand the importance of notifying the nurse if I hear my pump beeping.
20. I understand pain medications will not be adjusted over the phone and understand if my pain changes or increases, I must make an appointment to be seen in the office.
21. I understand that my pain is my pain, not my family's or spouse's and therefore, I need to be the person to communicate with the doctor and his staff if at all possible.
22. I understand I may see the nurse for some follow-up visits, but may schedule to see the doctor as I feel I need to.

I have read, understand, and will comply with this agreement. I have been given the opportunity to have my questions addressed regarding the above statements.

Name: _____ Date: _____

INFORMED CONSENT

I understand that taking opioid (narcotic) pain medication, especially on a long term basis, has been associated with the following: physical dependence (i.e., onset of withdrawal syndrome following a sudden reduction in dosage), tolerance, addiction (more likely in patients with a past history of drug/alcohol abuse), "hyperalgesia" (i.e., increased pain and pain sensitivity), altered hormonal activity, immune system changes, increased dental problems from "dry mouth syndrome", urinary retention, constipation, and alterations in mental functioning (most often as a results of frequent dosage adjustments).

I have read and I understand the above statement.

Name: _____ Date: _____

My family doctor is: _____ Phone #: _____

My medications will be filled at: _____ Phone #: _____