Tennessee Valley Bone and Joint
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(423)476-5554

The purpose of this agreement is to give you information about the medications and treatment you will receive for pain and to assure that you and your physician/healthcare provider comply with all state and federal regulations concerning the prescribing of controlled substances. We are not a registered pain mgmt. clinic.
I agree that my orthopedic care may include opioids (morphine-like drugs) as part of my treatment for pain. I understand that these drugs can be very useful, but have a high potential for misuse and addiction and are therefore closely controlled by the local, state, and federal government. Because my physician/health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

I am responsible for my pain medications. I agree to take the medication only as prescribed. I understand that increasing my dose without the close supervision of my physician/health care provider could lead to drug overdose causing severe sedation and respiratory depression and death.

I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at Tennessee Valley Bone and Joint.

There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing). It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion).

I am also responsible for notifying my practitioner immediately if I need to visit another physician/health care provider or need to visit an emergency room due to pain.

I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law**. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe.

If I have a history of alcohol or drug misuse/addiction, I must notify the physician/health care provider of such history since the treatment with opioids for pain **may** increase the possibility of relapse. Alcohol use is contraindicated. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity**.

I agree and understand that my physician/health care provider reserves the right to perform random or unannounced drug testing. **You may receive a call from our office to present for a random urine and/or pill count at our discretion.** If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the provider/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I understand that I am required to bring my pill bottle with me to every appointment before any additional prescriptions will be written.

I have read the above information or it has been read to me and all questions regarding my treatment have been answered to my satisfaction.

Patient Signature: _____ DOB: _____

Witness Signature: _____ Date _____