

**WELLNESS FIRST CHATTANOOGA, LLC / WELLNESS FIRST PAIN MANAGEMENT  
MEDICATION USE AGREEMENT**

I, \_\_\_\_\_, understand that I have chronic pain that has not been adequately controlled with other medications and that my function is limited by my pain. I understand that Wellness First Chattanooga, LLC, is prescribing controlled substances (such as opioid pain medications) to me and that the intent of the medication is to increase my ability to do more, and have a higher quality of life, although the medication is unlikely to eliminate my pain completely.

**Risks:** I am aware that the use of such medication has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, vomiting, itching, dizziness, allergic reaction, slowing of breathing, slowing of reflexes or reaction time, physical dependence on the medication, tolerance to the medication, and addiction to the medication if I do not take it exactly as prescribed (please see more information below regarding physical dependence, tolerance and addiction).

I understand and agree that I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or if I am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using/operating heavy equipment or driving motor vehicles, working at unprotected heights, or being responsible for another individual who is unable to care for him or herself.

**Other Treatment Options:** I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. These other treatments include physical therapy, surgical intervention, spinal injections, and the use of non-opioid medications.

**Medication Use:** I will take the medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my Healthcare Provider. I will tell my Healthcare Provider at Wellness First Chattanooga, LLC, about *all* other medications I am taking and any other treatments I am receiving.

I understand that my pain medication can only be prescribed by my Healthcare Provider at Wellness First Chattanooga, LLC, and only according to the agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will *never* be provided by telephone.

I agree that I will not seek or accept any medications for pain other than those prescribed by my Wellness First Chattanooga, LLC, Healthcare Provider. "Medications for pain" includes prescriptions from other doctors (**EMERGENCY ROOM, DENTIST, PODIATRIST, ANY MEDICAL PROVIDER**) medications borrowed or accepted from family or friends, and any illicit or street drugs. You may be seen by the above areas but you can **NOT FILL A PRESCRIPTION FOR ANY PAIN MEDICATION. DO NOT USE ANY MEDICATION OVER 90 DAYS OLD; THIS INCLUDES MEDICATION YOU HAVE BEEN PRESCRIBED IN THE PAST.**

I agree to bring all of my medications in the most recent prescription bottle (regardless of whether or not they were prescribed by a Wellness First Chattanooga, LLC, Healthcare Provider) to every appointment, even if the bottle is empty. I understand that if I do not bring my medications with me, I will not be seen that day and my appointment will be rescheduled. I understand that my pills will be counted and that if it is determined that I have taken more of my medication than I should have, it will be addressed with my Healthcare Provider, and that if this occurs on a frequent basis, it can be cause for termination of this contract and I can be discharged as a patient.

**Withdrawal:** I am aware that certain medications such as nalbuphine (Newbain), pentazocine (Talwin), buprenorphine (Suboxone), and butorphanol (Stadol) may reverse the action of the medication I am using for pain control. Taking any of these medications while I am taking my pain medication can cause symptoms that feel like a bad cold, or flu, and are known as withdrawal symptoms. I agree not to take any of these medications and to tell any other physicians or Healthcare Providers I see that I am taking an opioid as my pain medication and cannot take any medication listed above, or any other opioid medication not prescribed by Wellness First Chattanooga, LLC.

**Addiction:** I am aware that addiction is defined as the use of medicine even if it causes harm, having cravings for the drug, the feeling I get from taking the drug (other than relief from my pain), the need to use the drug in ways not prescribed by my Healthcare Provider, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low as long as I take it exactly as prescribed. I am aware that development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my Healthcare Provider my complete and honest personal drug use history and that of my family to the best of my knowledge.

**Physical Dependence:** I understand that physical dependence is a normal, expected result of using these medications for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medication use is markedly decreased, stopped, or reversed by some of the medications listed above, I will experience a withdrawal syndrome. This means that I may have any or all of the following: runny nose, yawning, large pupils, “goose bumps”, abdominal pain or cramping, diarrhea, irritability, muscle aches, decreased or increased heart rate, agitation, insomnia, hot or cold flashes. This will occur throughout my body and this is a flu-like feeling. I am aware that opiate withdrawal is uncomfortable and typically not life-threatening. However, there may be a risk of serious complications, including a very small chance of death, if I have certain other health issues. If I do experience withdrawal and have any symptoms beyond those described above, I agree to go to the nearest Emergency Room to be evaluated and I agree to have someone else drive me.

**Tolerance:** I am aware that tolerance to pain medications means that I may require more medications to get the same amount of pain relief. I am aware that tolerance to pain medications does not seem to be a big problem for most people with chronic pain; however, it has been seen and may occur in me. If it occurs, increasing my doses may not always help and may cause non-reversible side effects. Tolerance or failure to respond well to opioids may cause my Healthcare Provider to choose another form of treatment. I understand that as part of my Individualized Treatment Plan at Wellness First Chattanooga, LLC, that I *will* participate in other forms of treatments that have been proven by research to reduce chronic pain. These treatments (including the use of certain supplements such as Omega 3 EFAs (fish oil), massage therapy, yoga, and psychological treatments) may also decrease the likelihood that I will develop tolerance to my medication and may help me in lowering my dosage of pain medication.

**For Males Only:** I am aware that chronic opioid use has been associated with substantially lower testosterone levels in males. This may affect my mood, energy level and stamina, sexual desire, and physical and sexual performance. I understand that my Healthcare Provider may check my blood to see if my testosterone level is low. If it is low, I will be given options to increase my levels, including the use of bioidentical hormone replacement therapy (HRT), which will be offered through Wellness First Chattanooga, LLC. I understand that the blood tests and costs of any HRT is not covered under my monthly fee but that I will be offered both the lab tests and cost of HRT at the same cost that Wellness First Chattanooga, LLC pays for these items (in other words, I understand that Wellness First Chattanooga, LLC, will not make a profit from offering the lab tests or the treatment itself).

**For Females Only:** If I plan to become pregnant or believe that I have become pregnant while taking my pain medication, I will immediately call my obstetric doctor and my Wellness First Healthcare Provider to inform them of my pregnancy. I am aware that, should I carry a baby to delivery while taking these medications that the baby will be physically dependent upon opioids when he or she is born. I am aware that the use of opioids is not generally associated with the risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have birth defects while I am taking opioids. If I find out that I am pregnant or I plan to get pregnant and I would like to wean off my pain medication or try to lower my dosage, my Healthcare Provider at Wellness First Chattanooga, LLC, will help me to do so and will offer alternative treatments that may help with my pain during pregnancy and breast feeding.

**Refills:** Medication refills will be provided only as written prescriptions or prescriptions electronically sent to my pharmacy. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working day’s notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.

**Lost or Stolen Medications:** I understand that lost or stolen medications will not be refilled *under any circumstances*, regardless of whether or not a police report has been filed. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. I understand that this type of medication may be sought by other individuals who have an addiction to the medication and it should be closely safeguarded. I understand that I need to take the highest possible degree of my medication and prescription. I agree to not leave my medication where others might see or otherwise have access to them, and this includes being discrete when taking my medication.

**Other Risks and Precautions:** I understand that, as a consequence of not understanding chronic pain, medication to treat my pain, and other related issues, law enforcement agencies (local police, County Sheriffs, State Patrol Officers, etc.) may target me if they are aware that I am prescribed opioid medication. I understand that despite having a valid and legal prescription for my pain medication, I may be subject to arrest and conviction for DUI (Driving Under the Influence) if driving while taking my medication, and that if I submit to a drug test and my medication is detected in my system, it is considered a DUI and I could face losing my driver’s license, court fines and even jail time. I understand that not carrying my medication with me reduces the chances of this occurring but does not prevent it. I understand that if I do carry my medications with me, I am required by law to carry my medications in the original prescription container as doing otherwise could result in a felony charge per pill. I understand that limiting the number of people who know that I take prescription medication for pain, and having someone who is not on a “scheduled” or opioid medication drive me to and from the pharmacy when I fill my medications *might* reduce the likelihood of being arrested for DUI.

**Diagnostic Tests:** I understand that my Healthcare Provider may require additional diagnostic tests (such as an MRI), and I agree to keep appointments when my Healthcare Provider refers me. My Healthcare Provider will send a report of my care and a copy of this agreement when a referral is made.

In addition to the above agreements, I accept the right of my Healthcare Provider medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than my Wellness First Chattanooga, LLC, Healthcare Provider.
2. I give, sell or in any way distribute prescribed medications to *any* other person(s).
3. I accept any prescription drugs that are not my own from any person
4. I in any way attempt to forge or alter a prescription.
5. My medical condition declines to the point at which, in the judgment of my Healthcare Provider, continued therapy with this medication presents a danger to my well-being or safety.
6. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my Healthcare Provider determines that I am no longer a good candidate to continue the medication.

**MONTHLY URINE DRUG SCREEN POLICY:**

I understand that my Healthcare Provider is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my Healthcare Provider’s discretion, I agree to cooperate with monthly drug testing. If I refuse to submit to a urine drug screen (or any other form of drug screen), I understand my medication will be stopped, and I will be terminated as a Member of Wellness First Chattanooga, LLC. . Additionally, I understand that if, according to my most recent prescription date, I should have opiates in my system but I do not (and it has been less than 5 days since my prescription ran out), I will not be refunded my monthly payment and I will not be rescheduled for another appointment. I understand that the National Prescription Database will be checked the day of my appointment and if I have filled any opiate prescriptions in the previous 21 days from any provider other than Wellness First Chattanooga, LLC, I will be turned away and my appointment will not be rescheduled. I understand that if it is determined that I am “doctor shopping” in an effort to obtain pain medication illegally, then it is the obligation of Wellness First Chattanooga, LLC, to call the proper authorities and report me.

For additional information on our Drug Screen Policy, please see the attached agreement.

**Pharmacy:** I agree to fill my prescriptions *only* at the pharmacy I list below. If I change pharmacies or my pharmacy does not have the prescribed medication in stock and will not have it by the time I run out of my current prescription, I will contact the Wellness First Chattanooga, LLC office and provide them with the name, address and phone number of the new pharmacy.

I understand and consent for my prescriptions to be sent to my pharmacy electronically whenever possible. By sending the prescription electronically, I am less likely to lose my prescription or to have my prescription stolen, and there is no chance that the prescription can be altered or changed. When electronic transmission of my prescription is not possible, I understand that my prescription will be printed on security paper that prevents alteration, photocopying, or other tampering.

Under no circumstances will I obtain opioid medications from more than one pharmacy at a time, as doing so is a felony offense. In order to verify appropriate medication use, my Healthcare Provider’s office will provide my chosen pharmacy with a copy of this agreement. My signature below provides my consent to provide a copy of this agreement to my pharmacy.

I understand that any alteration in my medication prescriptions may require a new written agreement.

Pharmacy name \_\_\_\_\_

Pharmacy address \_\_\_\_\_

Pharmacy telephone \_\_\_\_\_

**TO BE COMPLETED BY YOUR WELLNESS FIRST HEALTHCARE PROVIDER:**

Medication name, dose, number of pills prescribed and directions: \_\_\_\_\_

\_\_\_\_\_ Frequency of appointments \_\_\_\_\_ days

I understand that by signing this agreement, I am acknowledging that I understand the many potential risks and benefits of using opioid pain medication, the potential side effects of this medication, and that I must abide by the rules reviewed above (as well as the

attached Drug Screen Policy) and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my Healthcare Provider and Wellness First Chattanooga, LLC.

My signature below indicates that I have read this form or have had it read to me, and that I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily, and I give my consent for the treatment of my pain with opioid pain medication (as well as any non-opioid medication that my Healthcare Provider has prescribed to me).

\_\_\_\_\_  
Patient signature

\_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Healthcare Provider signature

\_\_\_/\_\_\_/\_\_\_  
Date

### **Addendum to Medication Agreement**

#### **MONTHLY DRUG SCREEN POLICY**

WE WANT YOU TO UNDERSTAND THE IMPORTANCE OF THE URINE DRUG SCREENS (THAT WILL BE DONE *EVERY* VISIT AT NO EXTRA COST TO YOU) TO HELPING WELLNESS FIRST CHATTANOOGA, LLC, A SAFE PLACE FOR PEOPLE WHO HAVE PAIN AND FOLLOW THE RULES THAT HELP CREATE AN ENVIRONMENT WITHOUT THOSE FEW WHO WANT TO ABUSE THE SYSTEM (AND WHO GIVE ALL PAIN PATIENTS A BAD REPUTATION AND CONTRIBUTE TO THAT STIGMA WE ALL HATE SO MUCH)! WE GREATLY APPRECIATE YOUR COOPERATION AND UNDERSTANDING.

PLEASE REMEMBER THAT IT IS THE POLICY OF WELLNESS FIRST CHATTANOOGA, LLC, TO **REFUND YOUR MONTHLY FEE *IF***:

- YOU LET A STAFF MEMBER KNOW THAT YOU WILL NOT PASS YOUR URINE DRUG SCREEN **BEFORE** LEAVING TRIAGE (TRIAGE IS WHERE YOUR BLOOD PRESSURE, WEIGHT, ETC., IS TAKEN) AT THAT POINT, YOUR APPOINTMENT *WILL* BE RESCHEDULED AND YOUR FEE *WILL* BE REFUNDED. HOWEVER, IF THIS OCCURS MORE THAN ONCE, **YOU WILL NOT BE RESCHEDULED FOR ANY FURTHER VISITS.**

IF YOU DO ***NOT*** TELL A STAFF MEMBER THAT:

- YOU WILL OR MIGHT FAIL YOUR MONTHLY DRUG SCREEN BY THE TIME YOU ARE FINISHED BEING TRIAGED, *AND* YOU TEST POSITIVE FOR A SUBSTANCE THAT SHOULD NOT BE IN YOUR SYSTEM (WHETHER ILLEGAL OR A PRESCRIPTION MEDICATION FOR WHICH YOU CAN NOT SHOW YOU HAVE A VALID, LEGAL PRESCRIPTION)
  - **AND/OR** MEDICATION THAT *SHOULD* BE IN YOUR SYSTEM IS ***NOT*** DETECTED,
- THEN YOU WILL *NOT* BE REFUNDED YOUR MONTHLY FEE, YOUR VISIT WILL END IMMEDIATELY AND YOU WILL *NOT* BE SCHEDULED FOR ANY ADDITIONAL APPOINTMENTS.**

PLEASE NOTE THAT IF YOU CHOOSE TO GO AHEAD AND SUBMIT TO THE URINE DRUG SCREEN AND YOU FAIL FOR ANY REASON, YOUR VISIT WILL BE TERMINATED AND YOU WILL NOT BE REFUNDED YOUR MONTHLY FEE, AND YOU WILL NOT BE RESCHEDULED ANY ADDITIONAL APPOINTMENTS. HOWEVER, IF YOU PASS THE URINE DRUG SCREEN THEN YOU WILL BE SEEN FOR YOUR VISIT.

**POLICY EXCEPTION:** THE ***ONLY*** EXCEPTION FOR THIS POLICY IS MARIJUANA, DUE TO THE LONG HALF-LIFE OF THC (THE LENGTH OF TIME IT TAKES FOR THC, THE METABOLITE OF MARIJUANA, TO LEAVE YOUR SYSTEM). SHOULD YOU TEST POSITIVE FOR THC ON YOUR URINE DRUG SCREEN DURING YOUR **VERY FIRST VISIT**, YOU WILL STILL BE SEEN BY YOUR HEALTHCARE PROVIDER, BUT WITH THE UNDERSTANDING THAT YOU WILL STOP ANY FURTHER USE EFFECTIVE ***IMMEDIATELY***. IF THC SHOWS UP IN YOUR URINE DRUG SCREEN DURING YOUR **SECOND** VISIT, IT WILL BE SENT OFF FOR A QUANTITATIVE ANALYSIS AND YOU WILL BE CHARGED A **FEE OF \$125** (IN ADDITION TO THE FEE FOR YOUR MONTHLY VISIT). YOU WILL BE SCHEDULED FOR ANOTHER APPOINTMENT BUT IF WE RECEIVE THE RESULTS OF THE QUANTITATIVE ANALYSIS (WHICH WILL BE PRIOR TO YOUR NEXT/THIRD APPOINTMENT) AND YOUR LEVELS ARE HIGHER THAN THEY SHOULD BE IF YOU ACTUALLY STOPPED USING MARIJUANA IMMEDIATELY FOLLOWING YOUR FIRST VISIT (AND THEREFORE YOU HAVE HAD AN ADDITIONAL 30 DAYS FOR THE THC TO LEAVE YOUR SYSTEM), THEN THE STAFF OF WELLNESS FIRST CHATTANOOGA, LLC, WILL CONTACT YOU AND INFORM YOU OF THE RESULTS OF THE QUANTITATIVE ANALYSIS AND YOUR APPOINTMENT WILL BE CANCELLED AND YOU WILL ***NOT*** BE SCHEDULED ANY ADDITIONAL VISITS.

**MONTHLY URINE DRUG SCREEN FEE:** ALTHOUGH THERE WILL NOT BE AN ADDITIONAL FEE FOR YOUR MONTHLY URINE DRUG SCREEN, IF THE STAFF OF WELLNESS FIRST CHATTANOOGA, LLC, MAKES THE DETERMINATION THAT IT IS NECESSARY TO **RETEST** YOUR DRUG SCREEN, YOU WILL BE REQUIRED TO PAY AN **ADDITIONAL FEE OF \$50**. PLEASE NOTE THAT AT LEAST ONE QUANTITATIVE ANALYSIS A YEAR IS REQUIRED.

**PLEASE NOTE:** IF THE FOLLOWING SUBSTANCES ARE **EVER** DETECTED IN A DRUG SCREEN, YOU WILL BE TERMINATED FROM THE PRACTICE AND YOU WILL NOT BE SCHEDULED FOR ANY FURTHER APPOINTMENTS. THE ONLY EXCEPTION IS IF YOU CAN SHOW PROOF THAT YOU HAVE COMPLETED AT LEAST 3 MONTHS OF INPATIENT DRUG REHAB OR 12 MONTHS OF OUTPATIENT REHAB – IN THAT CASE, IT WILL BE AT THE DISCRETION OF THE OWNERS WHETHER TO READMIT YOU AS A MEMBER OF THE PRACTICE. THE DRUGS THAT WILL RESULT IN IMMEDIATE TERMINATION ARE:  
METH (METHAMPHETAMINE) CRACK COCAINE OR ANY OTHER FORM OF COCAINE PCP  
AMPHETAMINES (WITH A VALID PRESCRIPTION & CONSENT TO LET US SPEAK TO THE DOCTOR)

**URINE DRUG SCREEN PROCEDURE:**

PLEASE NOTE THAT OUR URINE DRUG SCREENS CAN DETECT ANY “ADULTERATION” – MEANING THAT THE TEST CAN DETECT IF THE URINE IS NOT YOURS, IF YOU HAVE ADDED ANYTHING TO YOUR URINE, ETC. **IF YOU TRY TO FASISFY A DRUG TEST; YOU WILL BE DISCHARGED AND WILL NOT GET A REFUND!**

WHEN COMPLETING THE URINE DRUG SCREEN, YOU WILL BE REQUIRED TO:

- TAKE OFF ANY JACKET OR COAT
- EMPTY THE CONTENTS OF YOUR POCKETS
- LEAVE PURSES, BACKPACKS, ETC., OUTSIDE OF THE LAB RESTROOM

ADDITIONAL PRECAUTIONARY STEPS INCLUDE:

- THE WATER TO THE SINK WILL BE TURNED OFF (HAND SANITIZER WILL BE AVAILABLE)
- THE WATER IN THE TOILET BOWL WILL CONTAIN DYE
- THE DOOR TO THE RESTROOM WILL REMAIN SLIGHTLY OPEN TO DETECT ANY UNUSUAL BEHAVIOR THAT WOULD INDICATE IF SOMEONE IS TRYING TO USE URINE FROM SOMEONE ELSE IN A CONTAINER SUCH AS A CONDOM, ETC., WHILE TRYING TO ALLOW YOU AS MUCH PRIVACY AS POSSIBLE
- YOU WILL NOT BE ALLOWED TO FLUSH THE TOILET UNTIL AFTER THE TEST IS COMPLETED
- ANY AND OTHER STEPS THAT ARE NECESSARY TO DETERMINE IF ANY ATTEMPT IS MADE TO PROVIDE ANY URINE OTHER THAN YOUR OWN, COMING DIRECTLY OUT OF YOUR URETHRA (THE TUBE THAT CARRIES URINE OUT OF THE BLADDER), OR ALTER THE CONTENTS OF THE URINE BY ANY MEANS

SHOULD YOU NOT BE ABLE TO PROVIDE A URINE SPECIMEN FOR ANY REASON, YOU WILL BE ALLOTTED 30-60 MINUTES TO PROVIDE THE URINE SAMPLE. **SHOULD YOU NOT BE ABLE TO COMPLETE THE URINE DRUG SCREEN WITHIN 60 MINUTES YOU WILL BE REQUIRED TO PROVIDE A BLOOD OR HAIR SAMPLE. THE FEE FOR THE BLOOD TEST WILL BE \$125 AND THE FEE FOR THE HAIR ANALYSIS WILL BE \$250 AND THOSE FEES WILL BE DUE AT THE TIME OF THE VISIT. IF YOU REFUSE TO COMPLY WITH A BLOOD OR HAIR SAMPLE TEST, THEN YOU WILL BE TERMINATED FROM THE PRACTICE AND YOUR MONTHLY FEE WILL NOT BE REFUNDED.**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE URINE DRUG SCREEN POLICY (OR HAVE HAD SOMEONE READ IT TO YOU) AND THAT YOU HAVE ASKED ANY QUESTIONS YOU MAY HAVE (AND HAVE RECEIVED AN ANSWER TO YOUR QUESTIONS), PRIOR TO SIGNING BELOW, AND THAT YOU UNDERSTAND:

\_\_\_\_\_  
MEMBER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
MEMBER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
STAFF MBR CONDUCTING TEST

\_\_\_\_\_  
DATE

\_\_\_\_\_  
STAFF MBR CONDUCTING TEST

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF HEALTHCARE PROVIDER

\_\_\_\_\_  
DATE