Nathan Miller, M.D -Michael Sebahar, M.D -Yogesh Patel, M.D. –Joshua Pal, M.D.

Coastal Pain and Spinal Diagnostics
Medical Group

Phone: (760) 753-7127 Fax: (760) 334-0399 www.CoastalPainGroup.com

Treatment Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

I, _____ understand that the possible complications of chronic opioid therapy
(Print Name)

may include:

- Constipation, dry mouth, nausea, vomiting, or decreased appetite;
- Dizziness, tiredness or lightheadedness;
- Respiratory depression;
- Interaction with other medications
- Muscle twitches, sweating, itching;
- Decreased urination;
- Decreased sex drive and sexual dysfunction
- Hypogonadism with secondary osteoporosis
- Physical dependence;
- Addiction;
- Over dosage and death;
- (Females ONLY) Chronic substance use may pose serious risks to fetus, therefore contact your provider immediately if you are or suspect you may become pregnant.

If you experience any of the following serious side effects, stop taking the narcotic and seek immediate emergency medical attention:

- An allergic reaction (difficulty breathing; closing of your throat; swelling of your lips, tongue, or face; hives);
- Slow, weak breathing; or any breathing difficulties;
- Seizures;
- Cold, clammy skin;
- Severe weakness or dizziness;
- Unconsciousness

Narcotics can be habit forming. Do not stop taking them suddenly.

Side effects other than those listed here may also occur. Consult our doctor about any side effect that seem unusual or that is especially bothersome.

1. I agree to follow the dosing schedule prescribed to me by my provider. **Use of my medication at a greater rate may result in my being without medication for a period of time or discharged from the practice.**

2. I will **NEVER** share, sell or exchange my medication with anyone for any reason.
3. I understand that I am solely responsible for the safe keeping of my medications. I will treat my medications as I would any valuable possession. I know that it is at **Coastal Pain's discretion to replace LOST OR STOLEN prescriptions or controlled medications and that such situations will subject my case to a thorough review in addition to urine screens and random pill counts.**
4. I understand that I should not drive or operate heavy machinery while I am taking medications that are causing drowsiness or impaired cognitive function. Please refer to the "***Driving While on Medication"*** handout.
5. I agree to notify Coastal Pain if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused mediation to Coastal Pain for disposal.
6. I agree that if I receive a controlled substance prescription from Coastal Pain, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7. I understand that my provider may routinely obtain Patient Activity Reports from the California Department of Justice, which provides a list of all controlled medications that are filled at all pharmacies. As a pain management patient I acknowledge that I will be subject to **random Urinalysis (usual frequency about four times per year) or Serum Toxicology and pill counts**. **I understand that there will be an additional cost of the Urinalysis/ Serum Toxicology that I will be responsible for. If the results of the screen test positive for illegal drugs, or do not reflect medicine prescribed by my doctor, I understand that I may be referred for further assessment and or dismissed from the practice.**
8. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled appointment with my provider in the office, and telephone request for narcotic medication refills will not be honored. I understand that if I run out of my narcotic medications due to overuse or loss of medications I may not be able to obtain early refills. I understand that being without my narcotic medications can lead to withdrawal and other adverse effects, and may be required to go the Emergency Room/Urgent Care if I experience any adverse effects from not having my medications. For refill requests for non-narcotic medications please allow 3-5 days to process.
9. I know that I may be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a Pill Count.
10. I understand that Coastal Pain Medical Group may write narcotic medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days (but no sooner than 28 days) of the date on my current prescription, so my doctor can properly evaluate my progress. Exceptions may be made at the provider's discretion only.
11. **I understand that my regular monthly medication refills will NOT be honored after regular business hours, over weekends or on holidays.** In rare exceptions, a small amount may be written to meet the next appointment.
12. The prescribing physician or physician's assistant has my permission to discuss all diagnostic and treatment details with my dispensing pharmacist or any other professional who provides for my healthcare for the purposes of maintaining accountability.
13. I agree to use only **one** pharmacy for my pain-related medications. In the event, that circumstance requires the use of another pharmacy; I will notify Coastal Pain immediately and provide them with all pertinent contact information. The pharmacy I have selected is:

Pharmacy Name: _____ Phone: _____

Address: _____

14. I will keep regular appointments and will call at least 24 hours in advance if I have to reschedule or cancel. I understand that failure to cancel a scheduled appointment 24 hours in advance and not showing up for a scheduled appointment will result in a $50 **NO SHOW** fee.
15. I understand that medications may not be given for cancelled or no-show appointments. I also understand that if I am more than 10 minutes late to my scheduled appointment time, I will have to reschedule for another time, and may be subject to the No Show fee.
16. I understand that I must have an appointment to be seen in the office.
17. Coastal Pain Medical Group phone triage hours are from 8:00 am to 4:30 pm, Monday through Friday for **NON-EMERGENCY medication questions and refill requests.** I understand that Coastal Pain has a 24 hour Emergency Line and if for some reason I am unable to reach a provider that I will immediately go to the Emergency Room for evaluation and treatment.
18. I understand that abusive behavior or harassment toward any Coastal Pain Staff cannot be tolerated. The Doctors will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
19. I understand that dealing with a forged, falsified or altered prescription will result in my **immediate dismissal** from Coastal Pain Medical Group.
20. I authorize my provider and my pharmacy to cooperate fully with any city, state or Federal Law Enforcement Agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my provider to submit a copy of this agreement upon request. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
21. Additional services and lab work, such as Urine/Blood Drug Screens (UDS) will be billed separately from the standard office visit charge.
22. The risks and potential benefits of these medication therapies or procedures are explained elsewhere (and I acknowledge that I have received such explanation).
23. **I attest that I am not a risk to myself or others.**

By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and that I have read, understood and accepted these terms. Non-compliance with this agreement can be terms for dismissal from the practice.

Patient Signature _____ Date _____

Patients Name (Printed) _____

Contracted Insurance Company

Please review our contracted insurance list. Please be aware that contracts are subject to change. If you do not see your insurance listed, please contact our office for clarification as we may **NOT** be contracted with your carrier.

Aetna	Medicare	Blue Shield	Scripps Health Plan
Cigna	Coventry	HealthNet	United Healthcare
Great West HMO	Blue Cross of California	Humana (Choice Care Network)	
Scripps Mercy Physician Partner IPA		Pacific Foundation for Medical Care	