Kanuru Interventional
Spine & Pain Institute
Ramesh P. Kanuru, MD FACA
Board Certified in Pain Management

CONSENT FOR CHRONIC OPIOID/CONTROLLED SUBSTANCE THERAPY

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the Patient to abide by the terms of this Agreement will result in corrective adjustments to the treatment plan and may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor-Patient relationship.

Based on my statements to the doctor, and his review of my pain history and relevant medical records and tests, the doctor believes my medical condition causes me chronic pain, I understand and agree:

- That I must be seen **MONTHLY IN THE OFFICE** to get medication refills.
- Early refills will **NOT** be given. Renewals are based upon keeping scheduled appointments.
- That I may be required to get a yearly psychological evaluation because of the addiction potential of these medications.
- That all controlled substances must be obtained at the **SAME** pharmacy, when possible. If a pharmacy is out of your medication, it is YOUR responsibility to locate a pharmacy and inform the office.
- That I cannot share, sell or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.
- I will be required to take periodic Urine Drug Screens at the request of the provider. If I refuse random drug screening at any time while this agreement is in force, I will no longer be treated by the physicians of Kanuru Interventional Spine and Pain Institute.
- I cannot seek opioid prescriptions from any other physician while I am under the care of the physicians from Kanuru Interventional Spine and Pain Institute. I understand that if I do receive multiple prescriptions of opioids from other physicians, I will no longer be treated by the physicians of Kanuru Interventional Spine and Pain Institute.
- I will tell my doctor about all other medicines and treatments that I am receiving.
- I realize that all the medications have potential side effects. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them.Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the Patient to abide by the terms of this Agreement will result in corrective adjustments to the treatment plan and may result in the withdrawal of all prescribed medication by the Doctor, possibly causing Patient to experience withdrawal symptoms, and the termination of the Doctor-Patient relationship.

I agree to follow the terms of this agreement and I understand the risks, alternatives, and additional therapy associated with the use of controlled substances to treat my pain. I understand this document will be maintained as a permanent component of my chart.

Patient Signature_____ Date_____

Highland Office
3445 Ridge Road
Highland, IN 46322
Phone: (219) 838-1100

Pinnacle Hospital
9301 Connecticut Drive
Merrillville, IN 46307
Fax: (219) 923-3501

www.painkanuru.com