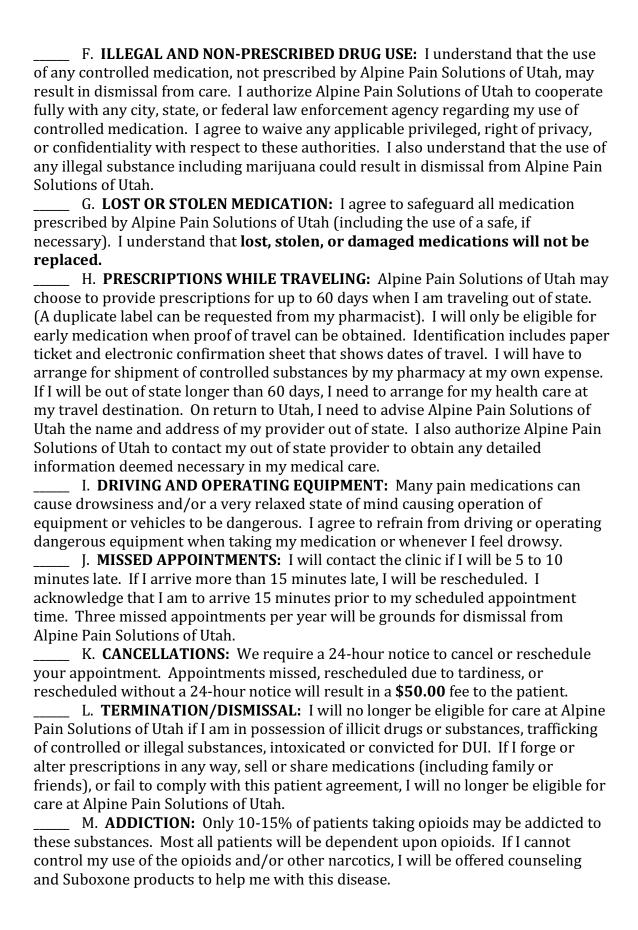
Alpine Pain Solutions of Utah Pain Management Patient Agreement

alpinepainsolutions.com

I,, understand that in order to receive care for	
the treatment of pain at Alpine Pain Solutions of Utah, I agree to comply with the	
following:	
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A. USE OF MEDICATIONS: I will take all medications as prescribed. I will	
speak with a provider at Alpine Pain Solutions of Utah before making any change in	
either the dose or frequency of taking my medication. There will be no early refills	
of pain medications due to taking more than prescribed (self-escalation). Narcotic	
pain medications must all be obtained from the same pharmacy (any exceptions	
must be approved by Alpine Pain Solutions of Utah).	
B. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for	
any medications related to pain relief from any other health care provider unless	
authorized by Alpine Pain Solutions of Utah.	
C. MEDICAL RECORDS RELEASE: I will inform all of my health care	
providers that I receive pain management through Alpine Pain Solutions of Utah and	
will maintain an unrestricted and current medical records release on file with	
Alpine Pain Solutions of Utah. I authorize Alpine Pain Solutions of Utah to provide a	
copy of the Pain Contract to release medical information to necessary pharmacies.	
D. MENTAL HEALTH: A mental health assessment and/or continuing	
psychological therapy may be required. If I am currently involved in mental health	
therapy, or if I enter such therapy, I will authorize my mental health practitioner to	
exchange unrestricted information regarding my condition and treatment with the	
healthcare providers of Alpine Pain Solutions of Utah.	
E. BENZODIAZEPINES: Because of the high risk of lethal effects of using	
benzodiazepines and opioid pain medications together, Alpine Pain Solutions of	
Utah does not prescribe them. If your mental health specialist feels that you need	
them for certain disease entities that there is no alternative, you will be required to	
sign a waiver acknowledging that you are aware of the risks. Every effort should be	
made to avoid the use of benzodiazepines and opioids together. Timing of the doses	
does not matter because both drugs remain in the system long enough to interact.	
D. DRUG SCREENING: I will participate in drug screening as part of my	
treatment plan. I understand that drug screening will be conducted randomly and	
the frequency of testing will be at the discretion of Alpine Pain Solutions of Utah.	
Screening may include urinalysis, oral sample testing, blood testing and/or pill	
counts. I agree to pay any and all costs associated with drug testing not covered by	
my insurance. Refusal to submit to screening at the time specified may result in	
dismissal from Alpine Pain Solutions of Utah.	
E. ALCOHOL USE: Any use of alcohol while being treated with prescription	
pain medication is against clinic policy. Testing for alcohol use is routinely tested	
for with drug screening at Alpine Pain Solutions of Utah. Any use of alcohol deemed	
inappropriate by the provider will be grounds for dismissal from Alpine Pain	
Solutions of Utah.	
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N. CHARGES: All fees from patients are due at the time of	of visit. Non-
payment of fees will hold prescriptions and may result in the acc	count being sent to
collections and patient dismissal from Alpine Pain Solutions of U	tah.
O. TREATMENT OF STAFF: Our clinic has a zero toleran	ce policy for verbal
abuse towards our staff. We understand that you are in pain and	l that can cause
anger and impatience. Swearing, yelling at, or threatening our st	
dismissal from the clinic. We will also ask that you treat the staff	
no flirting, which is inappropriate behavior.	r
P. EMERGENCY ROOM VISITS: I am allowed to receive p	pain medication in
the emergency department or urgent care center, but it is a viola	
Pain Solutions patient agreement (contract) to receive narcotic r	-
home. The provider may address the issue with the on-call prov	
Solutions of Utah.	
I HAVE THOROUGHLY READ THIS AGREEMENT BEFORE RECEIVING TRE. PAIN SOLUTIONS OF UTAH AND I UNDERSTAND AND AGREE TO THE COMPLY WITH THEM. ALL OF MY QUESTI TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED. I KNOW THAT FAWITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMED TERMINATION OF SERVICE.	NDITIONS OF CARE IONS ABOUT THE ILURE TO COMPLY
Reviewed contract and answered all patient's questions (MA):	Date://
Patient's Signature:	Date://
Provider's Signature:	Date://