Join Our Alliance of Patients, Physicians, & Pharmacists Fighting Diversion of Rx Pain Medicine!

Become a PPPFD Member & Enjoy The Benefits!

As a law-abiding member of PPPFD Alliance, PPPFD will ensure you have legitimate and reliable access to legitimate physician medical care and respectful pharmacy services.

Chronic Pain Patient Membership Application

You must be a legitimate sufferer of chronic pain and always tell the truth about how bad you hurt and what you do with your pain medicine or what happens to your pain medicine after you receive it from the pharmacy.

Please provide evidence of your pain condition (Radiology/Lab Reports, Physician Diagnosis, etc.)

Printed Name of Patient: ____

Patient Date of Birth: ____

Patient Insurance Company: ____

Name of Desired Pharmacy: ____

Trustee Authorized to Pick Up Prescriptions for You: ____

Yes, I swear and affirm that I am a legitimate sufferer of chronic pain and that I will ALWAYS tell the truth to PPPFD Auditors, Physicians, and Pharmacists concerning the severity of my pain (how bad I hurt). ___ (Initial)

Yes, I swear and affirm that I am a law-abiding patient and that I will ALWAYS tell the truth to PPPFD Auditors, Physicians, and Pharmacists concerning the use of my pain medicine after I receive it. ___ (Initial)

Yes, I swear and affirm that I will actively help fight prescription drug diversion by agreeing to participate in random and unannounced pill counts and saliva drug tests in my home or local pharmacy. ___ (Initial)

Yes, I swear and affirm that I will actively help fight prescription drug diversion by agreeing to be enrolled and scan my fingerprints into the PPPFD BioMatrix Registry. ___ (Initial)

Yes, I swear and affirm that I will actively help fight prescription drug diversion by agreeing to alert PPPFD of ANY signs of prescription drug diversion within my clinic, pharmacy, and community. ___ (Initial)

Yes, I swear and affirm that I will comply with the PPPFD Conditions of Membership on the next page.

Signature of Patient: X______________________________________ Date_______________

Printed Name of Witness Below: ____

Signature of Witness: X_____________________________________ Date_______________

Conditions (Rules) of PPPFD Alliance Patient Membership:

1. Membership: Subject to PPPFD rules, which may change without notice. The application fee includes a Pre-Screen Drug Test/National Background Check/Risk Stratification Interview and first month membership fee ($25 higher for Non-State Residents). Membership fees are due on date of service and cover one 30 day period from payment date. Fees also include up to two trustee enrollees.
2. Membership Renewal: Contingent upon compliance with PPPFD rules.
3. Age Requirements: You must be 18 years or older unless pediatrician endorsement has been provided.
4. Dress Code: You must wear respectable, non-revealing clothing while in PPPFD clinics and pharmacies.
5. Payment: You must pay membership fees with cash or credit card.
6. You agree to use only one physician to prescribe all chronic opiate and adjunctive medications.
7. You agree to notify your PPPFD Auditor of ALL illegal or inappropriate physician/pharmacist conduct.
8. You agree to inform your PPPFD Auditor of ALL medications in your possession (home, car, workplace, etc.) prescribed over 30 days ago.
9. You agree to inform your PPPFD Auditor of any opiate medication or adjunctive analgesia from other physicians (which includes emergency room doctors or dentists).
10. You agree and understand that your physician, pharmacist, or PPPFD reserves the right to perform random or unannounced bodily fluid drug testing and pill counts. You agree to cooperate.
11. You agree that the presence of a non-prescribed drug(s) or illicit drug(s) in your body fluid sample can be grounds for termination of the Doctor/Patient relationship.
12. You agree to ensure PPPFD always has your most current phone number and address.
13. You agree to inform PPPFD of ALL your past, present, and future criminal arrests by law enforcement.
14. You agree that if you decide to not follow our instructions or refuse to provide a body fluid sample, you understand that your Doctor may change your treatment plan, including safe discontinuation of your opiate medications when applicable, or complete termination of the Doctor/Patient relationship.
15. You agree to use a PPPFD approved pharmacy to obtain all controlled substance prescriptions.
16. You agree to get ALL of your non-controlled chronic medications filled by the same pharmacy.
17. You agree that PPPFD performs random pill counts on a regular basis and that if your name is chosen, you will comply by producing your pills for verification at either the clinic, pharmacy, or your home.
18. You agree to NOT give, loan, or sell your medications to any other person because it is against the law!
19. You agree to NOT use any illicit dangerous substances such as cocaine, heroin, methamphetamines, etc.
20. You agree to protect your medication from loss or theft. Stolen medications must be reported to the police and to your PPPFD Auditor immediately.
21. You agree that if your medications are lost, misplaced, or stolen, your physician will NOT replace the medication and may taper down or discontinue your medications.
22. You agree to keep your pain medication in a safe and secure place, such as a locked cabinet or safe.
23. You agree to hold your physician and pharmacist harmless if you are arrested for selling your prescription pain medicine, doctor shopping, or any other crime involving your pain medicine.
24. You agree you will NOT sue or file a HIPAA complaint against your physician or pharmacist if you are arrested for selling/trading/giving your pain medicine to ANYONE including family or friends.
25. By signing this form and enrolling into the membership program, I understand that I am authorizing PPPFD physicians, pharmacists and Auditors to protect my health information according to relevant healthcare and privacy laws.

Signature of Patient: X_______________________________________ Date_______________

P.S.
Do you know someone who sells their pain medication? Are you tired of their selfishness jeopardizing your legal access to pain medication? PPPFD is offering a **$500.00 Reward** for information that leads to the arrest of any PPPFD Alliance members who sell, share, or loan their pain medication! Call our hotline **304-894-8913**.