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Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing these pain-control medicines, either immediately or after a rapid taper off the medicine. Also, a drug-dependence treatment program may be recommended.

Date of Agreement:

_____

Patient signature:

_____

Physician signature:

_____

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I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including cocaine, heroin, and methamphetamines.

I will not drink any alcohol while on opioid medications.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain opioid pain medicines from any other provider while receiving opioid medications from this office.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. Narcotic medication will not be prescribed or refilled by phone.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

I authorize my doctor to provide a copy of this agreement to my pharmacy.

I agree to waive any applicable privilege, or right of privacy or confidentiality, with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I have read, understand, and agree to this Pain Management Agreement.

All of my questions and concerns regarding treatment have been adequately answered.

A copy of this document has been given to me.

Revised 2/21/2019