FAMILY DOC'S CLINIC

BOARD CERTIFIED IN FAMILY PRACTICE

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Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicine 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 agree to disclose a full list of medications that I am currently prescribed and taking.
I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship.
I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications.
I understand that my use of narcotic medication may impair my abilities, and thus I will not be able to operate heavy machinery, such as driving and that I should not make important decisions, or be at heights.
I understand that this restriction will apply unless I have informed my doctor that I am able to carry out my activities of daily living without impairment.
To ease the transition from taking narcotic medications, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms.
If needed, a drug-dependence treatment program may be recommended.
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 marijuana, cocaine, etc.
I will not share, sell or trade my medication with anyone.
I will not attempt to obtain controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
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 and will be prescribed within 48 business hours.
No refills will be available during evenings or weekends.
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 investigations of any possible misuse, sale or other diversions of my pain medicines.
I understand that short acting pain medications are not appropriate to treat long term chronic pain, I will work with my doctor to switch to a long acting pain medication.
I authorize my doctor to provide a copy of this agreement to my pharmacy.
I agree to waive any application privilege, 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 will **only** use _____ as my pharmacy.
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 medication to the office for disposal.
I understand that I may terminate this agreement at any time.
I understand that I will need to be evaluated every three months to continue pain management treatment.
The doctor may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.
I agree to follow these guidelines that have been fully explained to me.
All of my questions and concerns regarding pain management medication and dosing have been adequately answered.
A copy of this document has been given to me.

This agreement is entered into on this (date) _____.

Patient Signature: _____ **Print Name:** _____

Witnessed Signature: _____ **Print Name:** _____