



Agreement To Receive Chronic Pain Medications

You have seen a doctor in our office and he or she has evaluated you and elected to treat your painful condition. Sometimes, treating pain requires the use of a treatment plan/program involving drug therapy. There are many laws and regulatory guidelines concerning the use of prescription drugs and specifically controlled substances. Thus, the purpose of the Agreement is to prevent misunderstandings about certain medicines that your doctor recommends you take to help you manage your pain. We use this Agreement to help both this clinic and you comply with the laws and regulatory guidelines regarding the use of controlled substances to treat pain. Please read this agreement carefully and ask questions, if necessary. After reading the Agreement, please sign your name at the bottom of the last page, indicating your understanding of the conditions imposed upon you if you elect to undergo the recommended drug therapy program as part of your pain treatment plan/program.

Terms of the Agreement:

I understand 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 likely stop prescribing these pain-control medicines. If this happens, I understand that my doctor will taper off the medicine over a period of several days, as necessary, to avoid or minimize withdrawal symptoms. Also, I understand my doctor may refer me to a drug –dependence treatment program to help me, if necessary.

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, methamphetamines etc.

I will not share, sell, or trade my medication with anyone or take any one else’s medication.

I will not attempt to obtain any controlled medicines, including opioid pain medicines,

controlled stimulants, or anti-anxiety medications, from any other doctor or dentist. If an external provider is involved in issuing you a scheduled substance, prior approval from Pacific Coast Pain Management Center and documentation of this is required. I agree to disclose the names of my current and former doctors and dentists.

I will safeguard my pain medicine from loss or theft. I understand my doctor will not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my pain medication, I understand my doctor will discuss this issue with me and he/she may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of pain medications. I agree to these additional controls, which I understand include limitations on my supply of pain medications.

I understand my doctor has a strict policy regarding medication refills. Specifically, I understand my doctor will only provide me with refills of my pain medication during the time of my office visits or during regular office hours, subject to my valid need for the medication and not my need based on my failure to safeguard my medications, take them properly, etc. I understand my doctor will not make refills available to me during evenings or on weekends. I understand I am supposed to visit the emergency rooms for valid medical emergencies and not simply because I need or want more pain medication. I agree to go to the emergency room for valid medical problems, and I agree to inform my doctor of all such visits on the Monday following any such emergency room visit.

I will inform my doctor of my pharmacy of choice for the filling of all my scheduled substance pain medications.

I authorize my 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 and my pharmacist to talk about my pain medications and all aspects of my pain treatment plan/program, including any issues that may arise concerning potential substance abuse or diversion of pain medications. By my signature below, I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations and all underlying information relating to my pain treatment plan/program and the use of controlled substances to treat my pain.

I agree to submit a blood or urine test, if requested by my doctor or doctor's representative. I understand my doctor will use these tests to determine my compliance

with my pain treatment plan/program, including my use of pain control medicine. I agree to use my medicine as prescribed. I understand my doctor may discontinue treating me with pain medications if I take less or more pain medication than prescribed. I also understand that my use of pain medications at a greater rate than prescribed will result in my being without this medication for a period of time.

I will bring all unused pain medicine to every office visit. I understand my doctor or a member of his staff may count my unused medication(s) to ensure my compliance with my pain treatment plan/program.

I agree not to swear, abuse, or threaten the doctor or his staff. I am not to call the office multiple times during the same day. This is considered harassment, and may effect the doctor's decision to continue to provide me controlled substances or continue to retain me as a patient.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on _____

Patient signature: _____