Martin Medical Center, P.C.
Annual Pain Management Agreement

Patient Name: _____ Date: _____

I understand that _____ is prescribing opioid and/or other controlled medication(s) to help me manage my chronic pain and/or other health conditions that have not responded to other treatment methods. The goal of this medication therapy is to lead to partial relief from pain and/or to manage other health conditions, so that my physical, emotional, and social function will improve. If my activity level or general function gets worse, the medication(s) may be stopped or changed to something else. The risks, side effects and benefits of the use of controlled medication therapy have been explained to me and I agree to the following instructions. Failure to follow these instructions may result in stopping the medication.

1. I will participate in any **other treatments** recommended by my provider. I will be ready to decrease or stop the controlled medication therapy when other effective treatments become available.
2. I will take my medication exactly as prescribed and will not change the medication schedule or dosage without advance approval from my provider. **I will not request early refills**. I will provide my medication for pill counts at the provider's request. I must present for the pill count on the same day of the provider's request.
3. I will keep **regular appointments** for chronic pain management and monitoring of my health conditions with my provider.
4. If I feel I need changes in my controlled medication therapy I will schedule an appointment to see my provider.
5. All opioid and other controlled drugs must be prescribed only by _____ or another Martin Medical Center provider.
6. I will inform my provider within a week of discharge if I am hospitalized for any reason, or if I have another condition that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants)
7. I will choose only one pharmacy where all my prescriptions will be filled. If I need to use another pharmacy due to the inability of my regular pharmacy to fill the medication, I will notify my provider immediately.

   Pharmacy Name: _____

   Address: _____
8. I understand that lost or stolen prescriptions **will not be replaced**, so I will keep my prescription and medication in a safe place. I will not under any circumstance sell, lend, or give my medication to others. **I will not request early refills.**
9. I agree to **avoid all illegal and recreational drugs (including alcohol)** and will provide urine and blood specimens at the provider's request to monitor my compliance.

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10. I agree to follow my provider's recommendations regarding the operation of motor vehicles or heavy machinery while taking this medication. Operating machinery, driving, or participating in many other activities could be dangerous while you are on narcotic medicine. You must agree not to participate in these activities if you feel that your participation could be dangerous and only with the approval of you provider.
11. I agree that refills of my controlled medication will be made only at the time of an office visit. There may be circumstances in which my provider may approve refills at other times, but this can only be requested during regular office hours, and only with my usual provider. If my provider is not available and I have tried to refill my medication as described above, another Martin Medical Center provider may refill the medicine for a short time until my provider is available.
12. 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.

I authorize my provider and my pharmacy to cooperate fully with one another and with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of my controlled medications. I authorize my provider 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.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____