Initial Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about medicines you will be taking for pain management, and to help both you and your doctor 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 may stop prescribing these pain-control medicines and may terminate me from Martin Medical Center.

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.

Female Only- I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my doctor if I believe I may be pregnant. I agree not to take any medication without approval if I become pregnant.

I will not use any illegal controlled substances (including marijuana, cocaine, heroin or other illegal substances).

I will not share, sell, or trade my medication with anyone. I will bring all unused pain medicine to every visit.

I will not attempt to obtain any controlled medicines, stimulants, or anti-anxiety medicines from anyone else.

I will safeguard my medicine. NO allowance will be made for lost or stolen medicine/prescriptions.

I agree that refills of my prescriptions for pain medicine will be made only during regular office hours. No refills will be available during evenings or on weekends. Refill requests may take up to 36 hours to complete.

I agree to use ONLY the following pharmacy for filling prescriptions of all my controlled medicines:

_____

Print Pharmacy Name Address Phone number

I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or 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 random drug testing, at my expense, to determine my compliance with my program. I agree to enter a drug treatment program if my physician recommends it.

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

I agree to follow this and other advice given by my healthcare provider or pharmacist. If the medication prescribed causes an adverse reaction, I will discontinue the medication immediately and notify my doctor.

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 this _____ day of _____, 20_____.

Patient Signature:_____

Physician Signature:_____ Witnessed By:_____