PriorityHealth

Pain Management Agreement

This Agreement explains my responsibilities when I start taking certain medicines for pain management, and it will help me and my doctor comply with controlled prescription drug laws.

My doctor agrees to treat me based on this Agreement. **If I break this Agreement, my doctor may stop prescribing my pain-control medicines.** (If this happens, my doctor will taper off the medicine to avoid withdrawal symptoms. A drug-dependence treatment program may be recommended.)

I will:

- Keep my pain medicine safe from loss or theft. Lost or stolen medicines will not be replaced.
- Communicate truthfully with my doctor about my pain and how strong it is, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
- Bring unused pain medicine to every office visit.
- Do a blood or urine test, if my doctor requests one, to make sure I'm taking my medicine correctly.
- Get refills of my prescriptions for pain medicine only during an office visit or regular office hours. No refills are available during evenings or weekends.
- Allow my doctor and pharmacy to cooperate with any law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible sale or misuse of my pain medicine. I also allow 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 will NOT:

- Use any illegal drugs, like marijuana, cocaine, etc.
- Share, sell or trade my medication with anyone.
- Modify my medicine for any reason. It's a federal offense to alter a prescription in any way. If I do this, my doctor may no longer allow me to be their patient.
- Try to get any controlled medicines, including pain medicines, controlled stimulants or anti-anxiety medicines from any other doctor.
- Take more medicine than I was prescribed. If I do, I'll have to stop using the medicine for a period of time.

I agree to follow the guidelines above, which were fully explained to me. All of my questions and concerns about my medicine were answered. A copy of this document was given to me.

I agree to use this pharmacy to fill prescriptions for all of my pain medicine:

Pharmacy name:_____

Address:_____

Phone number: _____

Date:_____

Patient signature: _____

Physician signature: _____

Witnessed by: _____