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PAIN MEDICATION AGREEMENT

The purpose of this agreement is to prevent misunderstandings about your pain management. This to help both you and your doctor to comply with the law regarding these drugs.

I understand that my doctor agrees to treat me based on this agreement.

I will not share, sell, or trade my medication with anyone.

I will not attempt to obtain any pain medicines from any other doctor or from any emergency room. Only the prescribing doctor will approve refills.

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. No refills will be available during evening or on weekends.

I understand that it may take up to 3 business days for medication refills to be addressed. It is my responsibility to notify the doctors office with that time frame in mind.

I authorize my doctor and my pharmacy to cooperate fully with law enforcement in the investigation of any possible misuse of my pain medicine.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my medicine.

I agree that I will use my medicine at the prescribed rate. Increasing the medication to a rate greater than the prescribed rate will result in my doctor stopping the prescription of pain control medicines.

I will notify the treating physician of any side effects or any intolerance to any pain medication by the next business day, including the name of any medication I stop taking before talking with the treating physician.

I authorize my physician to notify any other healthcare providers about concerns regarding the use of my pain medicines.

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 understand that if I break this agreement, my doctor will stop prescribing these pain-control medicines:

Patient Signature________________________________ Date______________________

Physician Signature______________________________ Date______________________