**PATIENT AGREEMENT FOR USE OF CONTROLLED SUBSTANCES FOR PAIN MANAGEMENT**

Patient Name: \_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_ Primary Care Physician Name: \_\_\_\_\_\_\_ Date:\_\_\_\_\_

Effective pain management requires that the patient and the physician work together. This agreement is designed to make sure that you understand our expectations. Please discuss any questions or concerns with your physician. It is important that you understand that if you do not fulfill your obligations in your care, we will be less effective in helping you and might have to stop treating you.

* I understand that the opiate medication, also known as a controlled substance, is strictly for my own use. I will never give the opioid medication to others. Giving or selling medicines is criminal act. Changing or forging a prescription is also a crime (felony).
* I will let you know about any medications prescribed for me by any other health care providers, and inform any other health care providers of my pain agreement with you.
* I will take my medications as prescribed. I will not take my medication in any way that is not authorized by you (or other physicians in your office), including stopping it, increasing the dose above the range on the bottle, sharing it, trading or selling it.
* I agree not to self-medicate or take any street drugs or recreational drugs during the course of treatment.
* I agree to inform you of any over-the-counter drugs, vitamin supplements, and herbal remedies I am taking.
* I give consent for urine screening (drug testing) at your discretion, at any time during treatment, and will be prepared to provide a urine sample any time I am in your office. I also agree to bring my medication in to the office for a pill count when requested.
* It is my responsibility to report side effects to my provider. I understand that controlled substances can be sedating, addictive and/or habit forming.
* I will not drive or operate motorized equipment after beginning pain medication or after a change (such as a dose increase) until I have assessed the effects of the medication. I will not drive or operate motorized equipment if I ever feel sedated or mentally impaired.
* I understand that you will prescribe enough medication to last until my next visit or next scheduled medication refill date, and that you will not provide additional refills before that.
* I agree to make active efforts to increase my physical activity, deal with any stress, anxiety, or depression, which worsen pain, and to take responsibility for improving my level of function, despite pain.
* I understand that refills for controlled substances are only given during clinic hours Monday through Friday and not given on any emergency basis, after hours, on weekends, or on holidays.
* I understand that prescriptions are like money, and that I will not expect to have any lost, stolen or misplaced medications or written prescriptions replaced. I agree to contact your office in the event that I have lost my medication or prescription, and that I may have to wait until my next visit or scheduled refill date.
* I am aware that prescription medications are potentially dangerous when not monitored by a physician, and are frequently the target of theft for illegal use. I will be responsible for making sure that my medications are hidden or secured. I will consider using a safe or some other mechanism to lock up my medications.
* I understand that I am required to schedule and keep all follow-up appointments as requested by you or call at least 24 hours in advance to reschedule my appointment.
* I understand that prescriptions for opiate medications will not be mailed. I will pick up my refill prescription at the office every month.
* If it appears to my physicians that there is no improvement to my daily function or quality of life from this medication, my opiate medication may be discontinued. I will gradually taper my medication as prescribed by my physician.
* I intend to keep the same pharmacy for filling prescriptions and obtaining refills. If a change of pharmacy is necessary, I will promptly notify you of my new pharmacy. PHARMACY NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* In addition to myself, I authorize the following people to pick up my narcotic prescription. I understand that they will be required to present identification and I am responsible for informing them of this.

NAME PERSON 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME PERSON 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I agree that I have read and understand the conditions above. My medical chart will be flagged to alert other providers I have signed this agreement. If I am not able to honor the commitments made in this agreement, I will notify you. I understand that failure to follow this agreement may lead to termination of this contract and, potentially, my care with you. If this occurs, I understand that I will be notified in person or at my last known address. Also by signing below, I am giving your office permission to share this agreement with other health care providers and pharmacists for coordination of care.

I authorize the release of any information, including this agreement and hospital records, by my physician or his/her designee to other health care providers, pharmacies, my insurance company, other reimbursing agencies, law enforcement, and other authorities as required by state and/or federal law. I also authorize any pharmacy to release information regarding my prescriptions. This agreement will be in effect until \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Patient signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Provider signature Date