Name: _____-_____ Chart # _____

OPIATE/PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I understand that there is a risk of psychological and or physical dependence and addiction associated with chronic use of controlled substances.

_____I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement.

_____ I understand that if I break this agreement, my provider may stop prescribing these pain control medicines.

_____ In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider 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.

_____ I will not use any illegal controlled substances. (Cocaine, Meth, Shrooms, etc.) Nor will I misuse or self -prescribe/medicate with legal controlled substances. Use of alcohol will be limited to time when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medication (s), including opioid pain medication, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medication will not be replaced.

_____I agree that refills of my prescription for pain medication will be made ONLY at the time of an office visit. No early fills.

_____ I agree that the office can call me in for a random pill count/random UDS at any time.

Name: _____ Chart # _____

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this authorization.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program Website periodically throughout my treatment period.

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

_____ I agree to follow these guidelines that have been fully explained to me.

_____ I agree to use this pharmacy _____ located at this address

_____ with the telephone number of
_____ for filling my prescription for all my pain medicine.

Patient Signature: _____

Print Name: _____

Date: _____

Provider Name: Saint Adeogba M.D.