PATIENT CONTROLLED SUBSTANCES & PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management, anxiety and/or sleep disorders. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

I understand this Agreement is essential to the trust and confidence necessary to a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand if I break this agreement, my doctor will stop prescribing these pain-control and/or other controlled medications. In this case, my doctor will taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

I will not use any illegal controlled substances, including but not limited to marijuana, cocaine, etc. I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from other physicians.

I will safeguard my medications from loss or theft. Lost or stolen medications will **NOT** be replaced.

I agree that refills of medications for any controlled substance medication for pain, anxiety or sleep will be made only at the time of an office visit or during regular office hours. NO REFILLS will be available during evenings or on weekends.

I agree to use _____ Pharmacy located at

_____ for filling ALL my controlled medications including those for pain, anxiety and sleep.

I understand my doctor and the pharmacy will cooperate fully with any city, state, federal law enforcement agency or regulatory board in the investigation of any possible misuse, sale or other diversion of my controlled medication(s). I authorize the provision of this Agreement to my pharmacy. I agree to waive any applicable right to privacy or confidentiality with respect to these authorizations.

I agree I will use my medicine at a rate no greater than the prescribed rate.

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 will be given to me.

This Agreement is entered into on this _____day of _____, 20_____.

Patient Signature: _____

Patient Name (Please print): _____

Witnessed by : _____Printed Name: _____