PAIN MANAGEMENT AGREEMENT

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

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

I understand that if I break this Agreement, my healthcare provider **will** stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days as necessary, to avoid withdrawal symptoms, except in cases of trafficking with the medication or when a urine drug screen is negative for the prescribed medication. Also, a drug-dependence treatment program and referral to a pain management specialist may be recommended.

I will communicate fully with my medical 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, including marijuana, cocaine, etc.

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

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor without alerting my Carolina Family Health Center, Inc. medical provider.

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 the evenings or on weekends.

I understand my medical provider will utilize the NC Controlled Substance Reporting System Database to monitor my prescription activity.

I agree to use the pharmacy,_____

located at, _____

telephone number, _____for filling prescriptions

for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, in the investigation of any possible misuse, sale, or other diversions of my pain medicine. I authorize my medical provider 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 agree that I will submit to a blood or urine test, if requested, by my medical provider to determine my compliance with my program of pain control medicine.

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

I will bring all my pain medicine including empty bottles to every office visit.

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.

This Agreement is entered into on this day of _____

Patient's Signature:_____

Medical Provider's Signature: _____