PHYSICIANS PAIN CENTER

MEDICATION MANAGEMENT AGREEMENT

CONSENT FOR CHRONIC OPIOID THERAPY

This agreement between ____________________________ (Patient) and Physicians Pain Center (PPC), is for the purpose of establishing an agreement between PPC and the patient on clear understanding of the conditions for the prescription and use of pain controlling medications prescribed by the physician for the patient. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship.

______ I understand that a reduction in the intensity of my pain and an improvement in my quality of my life are the goals of this program.

______ I understand that all pain medications have potential side effects that include, but are not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, allergic reaction, slowed reflexes and reaction times, physical dependence, tolerance to analgesia, addiction and incomplete pain relief. I agree to report any concerning side effects to my provider at PPC in a prompt manner.

______ I understand that certain pain medications are classified as "controlled substances" and are governed by strict laws and that I am required to take these medications EXACTLY as prescribed by the provider and NOT make any changes without first discussing these changes with my provider.

______ I understand it is my responsibility to keep others and myself from harm, including the safety of driving. If there is any question of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until I have been evaluated or I have not used my medication for at least four (4) days prior to performing the activity and that I will inform the PPC as soon as possible.

______ I will not use ANY ILLEGAL CONTROLLED SUBSTANCE which may include, but is not limited to, substances such as marijuana, cocaine, and methamphetamine.

______ I will NOT share, sell or trade my medication for money, goods or services.

______ I will not attempt to get pain medication from any other health care provider without informing them I am getting pain medication prescribed to me at the PPC.

______ I will discontinue all previously used pain medications, while getting pain medication from PPC, unless told to continue them by the physicians at the PPC.

______ I understand I am solely responsible to safeguard my medication from loss or theft and if my medication is lost or stolen, I may not receive more from the PPC, which I understand may put me into withdrawals.

______ I agree to provide the name of the sole pharmacy I will use to acquire my pain medication and if there are any changes, to advise PPC of the change.

______ I agree to submit a blood or urine test or oral swab test, as requested.

______ If the medication is not working, or there are adverse effects, I will make an appointment with my provider PRIOR to changing the way I take my medication.

______ I will not throw away any pain medication.

______ I understand that I may have to bring all my medications to my office visit.

______ I authorize my pharmacy to provide information about my prescriptions to the PPC at any time.

______ I agree to these terms and understand failure to abide by any of the conditions of the agreement may result in the discontinuation of the medications prescribed by the PPC.

______ I agree that I understand the above and that any questions have been answered.

This agreement is entered into record on this______ day of__________in the year__________.

Patient Name: ____

Provider Witness: ____

I UNDERSTAND THAT THIS CONTRACT IS A PART OF MY MEDICAL RECORD AND THAT I MAY ASK FOR AND RECEIVE A COPY FOR MY FILES.