Pain Treatment Agreement

1. I will be required to follow up with an office appointment every month while on this contract. If I fail to follow-up, I will immediately be discharged from this contract unless I make arrangements with this pain physician. I must bring a complete medication list of all medications & dosages currently taking.
2. I will know at all times how much medication I have remaining. Refill requests will be called in 3-5 working days before running out. NO refill requests will be processed on Friday or if received after 1400 (2:00 PM) on Thursday.
3. I understand that medications that "run out" over weekends or holidays will NOT be replaced until a regular working day.
4. I understand it is my responsibility to safeguard my medications. Should they be lost, stolen, destroyed or if they are used up early, the medication(s) will under no circumstances be refilled.
5. I understand that allowing others to use my medications or using medications not prescribed to me, will result in termination of care.
6. I agree not to sell, lend or in any way give my medication to any other person.
7. I understand that narcotic medication, as well as some other medications such as Soma (muscle relaxants), diazepam (Valium) or Clonazepam (Klonopin) can be habit-forming and may result in dependency or addiction.
8. I understand that stopping these medications abruptly may cause dangerous withdrawal symptoms including seizures. I have been informed not to stop any controlled pain·medications suddenly unless directed by a pain management provider.
9. I understand that these medications may cloud my judgment and adversely affect my ability to react. Therefore, my ability to make important decisions, to operate machinery, or perform similar activities may be depressed. Neuropsychiatric testing may be requested to help assess any functional impairment I may have.
10. I have been informed by my provider and I understand that I am not allowed to drive an automobile while taking narcotics or narcotic analgesics (opioids).
11. I will cooperate with interventions to decrease narcotic requirements including psychological modalities, physical therapy and/or invasive procedures.
12. I understand I may be subjected to random urine drug tests to verify compliance with medications and to check for illicit drug use. I understand I may have to assume part or all of the cost of said testing.
13. I understand that use of any illegal drugs, as verified by urine analysis, or improper use of prescribed medications are grounds for termination of care.
14. I understand that failure to obtain urine analysis within 24 hours of original request constitutes grounds for immediate discharge from the service.
15. I agree not to drink alcohol or use other mood-altering drugs while I am taking controlled pain medications.

16. If I am seen at any medical facility (i.e. urgent care clinic or emergency room), and given narcotics, I will inform my pain physician and bring him the discharge documents.
17. I understand that I can receive narcotic analgesics from other physicians for emergencies including dental, surgery and trauma. I will notify my pain provider of these situations and medications ASAP. ,
18. If an Arizona pharmacy report shows any other unauthorized prescriptions, I know I will be discharged from this contract.
19. If this pain provider feels that I am addicted to narcotics, I agree to see an addictionologist to undergo detoxification. My pain provider agrees to refer me to a physician if needed.
20. This contract can be terminated at any time by the patient or provider. A list of addictionologists will be available for me to use to come off the medication safely.
21. I understand that failure to follow any of these guidelines may result in termination of care.

A. Please list name & phone number(s) of Primary care Physician and all other physicians

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B. Please list the one pharmacy to be used (include cross streets and phone numberher):

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Patient Signature: ________________________________ Date: ______________________________