JOHNSON MEMORIAL HEALTH

1125 West Jefferson St. | Franklin, Indiana | 46131

PAIN TREATMENT AGREEMENT

This Agreement between _____ ("Patient") and Pain Consultants ("Doctor") is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program. _____**(initials)**
- I understand that my pain medication dosage may be tapered or discontinued if not effective. _____**(initials)**
- I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible. _____ **(initials)**
- I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until I have not used my medication for at least four days. _____**(initials)**
- I agree that refills of my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. I agree to give at least 7 business days' notice for refill requests. No refills will be available during evenings or on weekends. _____**(initials)**
- I will not use any illegal controlled substances, including marijuana, cocaine, etc. _____**(initials)**
- I understand that if I use medical or recreational marijuana, I will not be prescribed any opioids. _____**(initials)**
- I agree to refrain from all mind/mood altering/illicittaddicting drugs including alcohol and Benzodiazepines unless authorized by this pain center physician. _____**(initials)**
- I will not share, sell, or trade my medication for money, goods, or services. _____**(initials)**
- I will get all pain medication from ONLY ONE health care provider. If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure there isn't any duplication. **I WILL DISCONTINUE AND DISPOSE OF ALL PREVIOUSLY USED PAIN MEDICATIONS UNLESS TOLD TO CONTINUE THEM.** _____**(initials)**
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is a violation of this agreement, and I may no longer be prescribed opioid medication. _____**(initials)**
- I understand it is my responsibility to safely store my medication and to dispose of it appropriately. _____**(initials)**
- I agree to use (name of 1 Pharmacy) _____ located in _____, Telephone number _____,for all of my pain medication. If I change pharmacy for any reason, I agree to notify the Doctor at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy's address and phone number. _____**(initials)**
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication, and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this Agreement to my pharmacy. _____**(initials)**
- I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with this agreement and my regimen of pain control medication. _____**(initials)**
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate may result in significant harm and is a violation of this agreement. _____**(initials)**
- I will bring all unused pain medication to be counted by the nurse whenever requested. _____**(initials)**
- I agree that one missed appointment or cancellation would be a breach of the agreement and may lead to dismissal. _____**(initials)**