S.P.I.N.E. CENTER
Pain Management Agreement

Patient Name: _____

Date: _____

The use of controlled substances to treat pain conditions is a serious consideration. It is necessary for both you and your physician to comply with applicable state and federal laws regarding the use and prescription of controlled substances. In order to receive a prescription for controlled substances from this practice, you must adhere to the conditions listed below. **Failure to comply with this agreement may result in cessation of prescriptions and/or termination from the practice.**

CONDITIONS:

1. I agree to communicate fully and honestly with my physician regarding my condition and the character and intensity of my pain.
2. I will not use illegal substances, street drugs, or abuse alcohol while taking controlled substance medications.
3. I will not take any medications prescribed for other people.
4. I will not be involved in the sale, illegal possession, diversion, or transport of controlled substances.
5. I agree to safeguard my medications from loss or theft.
6. I agree to obtain drug screening tests, including blood alcohol levels, when my physician requests it.
7. I agree to obtain all prescriptions for controlled substances from one physician only and to take medications as prescribed by my doctor.
8. I agree to use only one pharmacy,_____, _____ phone number, for filling prescriptions for controlled substances.
9. I agree to follow up at least every three months with my physician regarding pain control and to keep all scheduled appointments regarding my pain.
10. I understand that a copy of this agreement will be kept in my medical record.
11. I understand that my physician may communicate with other physicians or pharmacists regarding my health care treatment and continuity of my care.
12. I certify that I am not pregnant.
13. I agree to contact the practice within 24 hours if an unavoidable emergency occurs requiring a prescription for controlled substances, an ER visit, or inpatient admission.

14. I understand that no allowances will be made for lost or stolen prescriptions, drugs, or any problems I may have with transportation or dates of pick up.
15. I understand the possible adverse side effects associated with controlled substances as disclosed to me.
16. I agree to have_____as a designated person to pick up my prescription if I am unable. He/she will present a photo ID to verify name and permission for pick up.
17. I agree to call 7 days in advance for all refills and will schedule a time for pick up.
18. I agree that I will not attempt to receive a prescription early.
19. I understand that I may not receive further prescriptions for controlled substances if I do not comply with this agreement, and my doctor will taper off the medication and a drug-dependence treatment program may be recommended.
20. I understand that failure to comply may result in termination from the practice.
21. I acknowledge that my physician may provide a copy of this agreement to the named pharmacy.
22. I acknowledge that a copy of this document has been given to me.

I have read this agreement, understand it, and have had any questions answered satisfactorily. I agree to comply with the terms of this agreement.

_____ _____
Patient name Date

_____ _____
Patient signature Date of Birth

_____ _____
Physician name Date

_____
Physician signature

_____ _____
Witness name Date

_____
Witness signature