OPIOID PAIN MANAGEMENT AGREEMENT

Doctor: Randall Rodgers, DO

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 doctor to comply with the law regarding controlled pharmaceuticals.

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

I understand that if I break this Agreement, my doctor 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. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor 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 agree to abstain from excessive alcohol use and 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.

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 evenings or on weekends.

I agree to use _____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, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor 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 doctor to determine my compliance with my program of pain control medicine.

I agree the medication must be *safe and effective* and help me to *function better*. The goal is to use the lowest dose that is both safe and effective. If my activity level or general function gets worse, the medication will be changed or discontinued by my doctor.

I will participate in *other treatments* that my doctor recommends and will be ready to taper or discontinue the opioid medication as other effective treatments become available.

I will take my medications exactly as *prescribed* and will not change the medication dosage or schedule without my doctor's approval. I agree to be seen by a nurse practitioner if my doctor determines my condition is stable.

I agree I may be subject to having my medication counted/inventoried through the process of random pill counts. Further, I agree that if I refuse to provide my medication(s) to be counted and/or examined within the timeframe allotted, I may be terminated from this practice.

One Doctor. All opioid and other controlled drugs for pain must be prescribed by the doctor who is named above. I will not obtain medications from other doctors or pharmacies unless I am hospitalized. I will tell any hospital or emergency room doctors that I receive pain medications from my provider. In the event of an emergency, if I am given a prescription for pain medication, I will notify my pain doctor as soon as I am able.

I understand that clinic staff (nurses, receptionists, lab staff, etc.) is very important in my success with this treatment plan. I will treat them respectfully and abide by their decisions regarding my care and the enforcement of this agreement.

If I am unable to follow the conditions of this agreement, I understand it may not be safe for me to continue opioid medications.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____