



Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines that you will be taking for pain management. This agreement is intended to protect your access to controlled substances and protect our ability to prescribe for you. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. This agreement is valid indefinitely throughout your care with Riverside Spine and Pain Physicians.

The long-term use of controlled substances such as opioids, benzodiazepines tranquilizers, and barbiturate sedatives is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when the use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness to treat your chronic pain.

I understand that all controlled substances must come from my pain physicians at Riverside Spine unless specific authorization is obtained for an exception. I understand that multiple prescribing sources are illegal in Florida. I will not obtain pain medications from any other physicians. Doing this will constitute a breach of this contract and will immediately end any and all responsibility on behalf of my physician for further care.

I will communicate fully and honestly 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 am expected to inform the pain clinic of any new medications or medical conditions, and of any adverse effects that I experience from any of the medications that I take.

I understand that the risks associated with controlled medications include dependence, addiction, tolerance and constipation, sleep changes, potential for increased pain, risk to unborn children, withdrawal, and changes in appetite, coordination, sexual desire and sexual performance.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. while under the care of Riverside Spine and Pain Physicians. I understand that my urine and/or blood may be tested at any time for levels of controlled substances in my system. If any are discovered on random drug screens, I may not be able to get prescription refills of narcotics. I will not share, sell or trade my medication with anyone. I will not alter my prescriptions under any circumstance, and understand that you keep copies of all prescriptions. I agree to keep all medications out of the reach of others, including pets and children, as they may be hazardous or lethal to such individuals.

I agree to safeguard my pain medicine from damage, loss or theft and understand that damaged, lost or stolen medicines cannot be replaced. In the event of theft, I must file a police report for replacement of narcotics. I will not discard or destroy any medications. I will bring any unused medications to the clinic for proper disposal. I understand that refills of my prescriptions for pain medicine can be made only at the time of an office visit. Narcotics cannot be prescribed after hours/ on weekends.

Even if I am on stable doses of controlled medication, I agree to schedule and keep regular appointments with my physician as part of my routine medical care. I understand that I am responsible for monitoring and scheduling ahead of time to ensure that my prescriptions will not run short on a weekend or holiday. I agree to meet all financial obligations associated with my treatment.

I agree not to drive, use heavy machinery, or perform any potentially dangerous activities that require my full concentration following the initiation or any changes in my medications. I understand that I should not resume such activities until I have been on a stable dose without side effects.

I agree to take all scheduled medications exactly as prescribed and not to exceed the maximum daily dose on medications. If I overuse medications without your explicit permission, they will not be replaced early. I further agree to inform my physician of any emergency medical treatment during which I received pain medications.

I understand that if I break any portion of this Agreement, my doctor may stop prescribing these pain-control medicines and may elect to discharge me from the clinic. In this case, my doctor may 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 agree to use only the pharmacy listed below for filling prescriptions of all controlled substances. I will notify my pain physician prior to changing my pharmacy for any reason.

Pharmacy	
Address	
Phone	

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 give my consent for the physicians and staff to speak with my pharmacist and other physicians to exchange pertinent information regarding my medical condition.

All of my questions and concerns regarding pain medication prescribing have been adequately answered. A copy of this document will be provided me upon request. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

Patient Sign:	Date:
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