Opiate/Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management.

This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

☐ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

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

☐ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

☐ In this case, my provider will taper off the medicine over several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

☐ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

☐ I will communicate fully with my provider 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 will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. The use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

☐ I will not share my medication with anyone.

☐ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

☐ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

☐ I agree that refills of my prescriptions for pain medications 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 this pharmacy _____ located at this address _____ with the telephone number of _____ for filling my prescriptions for all of my pain medicine. ALL MED Prescription Monitoring Program/Resources

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☐ I authorize the provider 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 diversions of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality concerning these authorizations.

☐ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

☐ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

☐ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

☐ I will bring unused pain medicine to every office visit.

☐ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. This Agreement is entered into on Date

Patient Signature:

Patient Name (printed):

Patient Cell: Pat. Email:

Provider signature:

Provider Name (printed): Dr Richard Beira, Medical Director

Witnessed by: Signature: Office Manager - All Med Medical Group

Name (printed):

METHADONE USERS ONLY

Methadone Clinic Name:

Phone Number

Social Worker Name

Methadone Dosage mg/day. Number of Days a week

I understand that if my methadone dose changes, I have to inform my Pain Management Doctor, otherwise I will be in violation of the contract.


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