XXXXX Hospital

PATIENT MEDICATION MANAGEMENT AGREEMENT

The control of pain is a significant part of medical practice. The physicians in this office strive to provide adequate pain relief to our patients. Pain control is required for three basic types of pain. The first is for acute, short-term problems such as toothache or kidney stone. The second is for long-term problems related to long-term conditions such as cancer. The third and most difficult type is the persistent pain for which there is no obvious cause of or which the underlying problem is on that does not usually result in long-term pain for most people.

Medications required to control pain are frequently of the type called "controlled substances". This means they have the potential for abuse by patients and practitioners, whether intentionally or unintentionally. Since we both play a part in the improvement of your health, we ask that you enter into the following agreement with us if you wish to continue to receive prescription pain medications from this office.

1. I understand I may have a chronic pain problem for which there is either no clear explanation or for which chronic pain is not the usual result.
2. I agree not to ask for opioid medications from any other doctor without the knowledge and consent of Dr. XXXXXXX
3. Prescription refills will be authorized only during regular office hours, with recommended therapists and counselors.
4. I agree to keep all scheduled appointments, not just with my physician, but also with recommended therapists and counselors.
5. No prescriptions will be refilled early.
6. No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen.
7. I agree not to give, sell, or otherwise provide this drug to anyone other than myself.
8. I understand that a risk of chronic narcotics treatment is physical dependence (withdrawal symptoms may occur if the medication is abruptly stopped.)
9. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
10. Urine or serum toxicology screens may be requested, and my cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

_____ _____

Witness Date