

Pain Treatment Agreement

I understand that I have a right to comprehensive pain management. I understand that this agreement aims to improve the safety and efficacy of pain management. I understand that failure to follow any of these agreed statements might result in Dr. _____ not providing ongoing care for me.

I, _____, agree to undergo pain management by Dr. _____.
My diagnosis is _____. I agree to the following statements:

I will not accept any narcotic prescriptions from another doctor.

I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications will cause severe withdrawal syndrome.

I understand that I must keep my medications in a safe place.

I understand that Dr. _____ will not supply additional refills for the prescriptions of medications that I may lose.

If my medications are stolen, Dr. _____ will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.

I will not give my prescriptions to anyone else.

I will only use one pharmacy.

I will keep my scheduled appointments with Dr. _____ unless I give notice of cancellation 24 hours in advance.

I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by Dr. _____

My treatment plan may change based on outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued. My treatment plan includes:

Medications _____

Physical therapy/exercise _____

Relaxation techniques _____

Psychological counseling _____

I understand that Dr. _____ believes in the following "Pain Patient's Bill of Rights."

You have the right to:

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits and side effects of treatment.
- Know what alternative pain treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your physician.
- Include your family in decision-making.

Termination Clauses

A. The doctor may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.

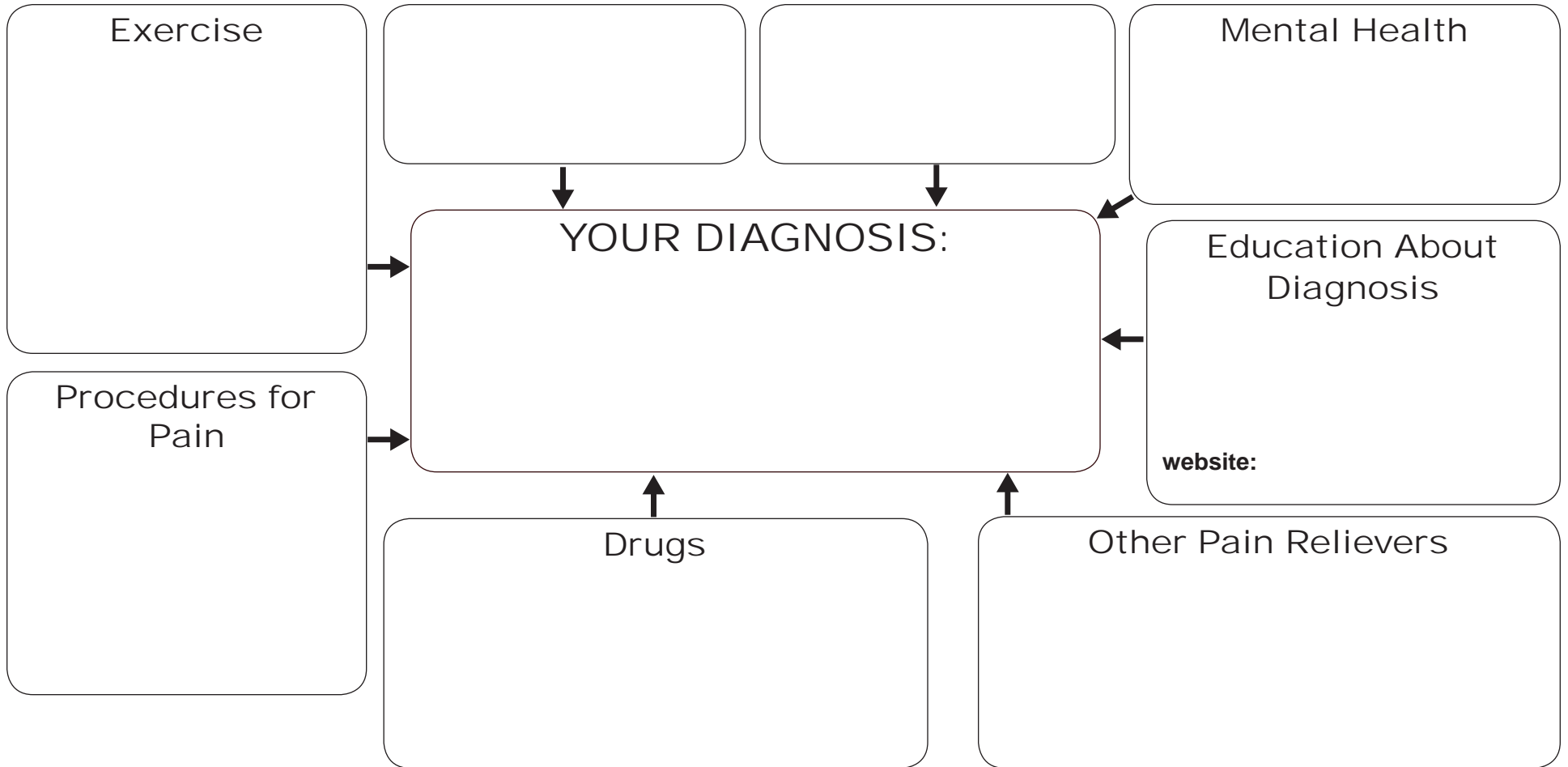
B. I understand that I may terminate this agreement at any time.

If the agreement is terminated, I will not receive prescribed controlled medications but can remain a patient of Dr. _____ and would strongly consider treatment for chemical dependency if clinically indicated.

_____ Patient Signature	_____ Date	_____ Prescriber Signature	_____ Date
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How You Can Help Control Your Pain

Your provider will review and write down the different ways that you can help yourself live and function with pain.



My Treatment Goals:

1. _____

2. _____

3. _____
