

Chronic Pain Management Agreement

The control of pain is a significant part of medical practice. The physicians and mid-level providers 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 a toothache or a 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 or for which the underlying problem is one 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 have a joint venture with you in providing your healthcare, 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 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 understand a risk of chronic narcotics treatment is addiction (compulsive use of a potentially harmful substance).
3. I understand that a risk of chronic narcotics treatment is physical dependence (withdrawal symptoms if the medication is abruptly stopped).
4. I agree to not use illegal substances, street drugs, narcotics prescribed for others or abuse alcohol while taking controlled medications.
5. I agree that I will obtain my pain control medications only from the office of Dr. _____ .
Dr. _____ will manage my medication program.
6. I agree to follow-up appointments with my provider at least once every three months and understand that keeping follow-up appointments are important to my medical care.
7. I agree that I will obtain my pain control medications only during regular office hours (8 a.m.- 6 p.m.) Monday through Friday.
8. I agree that I will not use my medications at a faster rate than prescribed and I will not request premature refill of my pain control medication.
9. I agree to drug screening tests and pill counts on provider request.
10. Females: I certify that I am not pregnant and I agree that I will use appropriate measures to prevent pregnancy during my course of treatment with narcotics.
11. I agree to contact __ (Dr.’s Office) __ within 24 hours if an unavoidable emergency occurs requiring a prescription for opioids, an ER visit, or an inpatient admission.
12. I understand the need to be discreet about possessing narcotics and keeping medications in an inaccessible place so they may not be stolen or accidentally ingested by another person or child. I understand that stolen or lost pain medications will not be replaced.
13. I agree not to give, sell, or otherwise provide this drug to anyone other than myself.
14. I agree that my having signed this agreement may be shared with area hospitals, pharmacies, and law enforcement agencies.
15. I understand that violation of this agreement will result in tapering and discontinuation of all pain medications, as well as reporting any illegal activity to the proper authorities.
16. I agree to review, update, and sign this agreement at least once per year.

Signature: _____ Date: _____ Witness: _____

Provider Signature: _____ Date: _____ Witness: _____

Signature: _____ Date: _____ Witness: _____

Provider Signature: _____ Date: _____ Witness: _____

Signature: _____ Date: _____ Witness: _____

Provider Signature: _____ Date: _____ Witness: _____

Signature: _____ Date: _____ Witness: _____

Provider Signature: _____ Date: _____ Witness: _____

Signature: _____ Date: _____ Witness: _____

Provider Signature: _____ Date: _____ Witness: _____

Medical Mutual offers this information as reference information only and is not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.