Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management and to ensure agreement between the practice and you about appropriate care. You agree to be responsible and compliant with the medical directions and advice provided at this office.

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

I understand that if I break this agreement, my doctor will use her judgment with how to respond but a break in this contract may result in the stopping that prescribing of medications and/or discharge from the practice. My doctor may taper of the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also a drug-dependence treatment program may be recommended.

I will communicate fully 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 will not use any illegal controlled substances, including marijuana, cocaine, etc. I understand that I will be tested periodically to ensure compliance and abnormal results could lead to the discharge from the practice or cessation of prescriptions.

I will not share, sell or trade my medication with anyone.

I will follow directions regarding the use of medication. I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants or antianxiety medicines from any other doctor. This could result in a discharge from the practice or cessation of future prescriptions by the doctor. If I do need to receive medication in an urgent situation, I will immediately advise the office and provide all medical records of that event.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I understand there will not be early refills.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours, as indicated by office policy assuming that labs are up to date. No refills will be available during evenings or on weekends.

I understand and agree to fill medications no earlier than once every thirty (30) days and that not refills will be given.

I will call the pharmacy for refill request 3 business days prior to date of next refill.

I understand that I must have an office visit prior to any medication changes.

I understand that taking these medications, including opiods and benzodiazepines can lead to respiratory failure, depression and even death. I will not use alcohol or any other substance while taking

the prescribed medications. I further understand that doing so increases the risk of harm or death. I also confirm that these medications can also cause other side effects including, dependence, tolerance, addictions, constipations, impair my ability to operate machinery or vehicles, and other complications.

I have reviewed the pharmacy insert for the medications I am receiving and aware of the risks involved with these medications.

I agree to use_____Pharmacy,

Located at _____,

Telephone Number _____, for prescriptions for all of my pain medicine.

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 or right of privacy or confidentiality with respect to these authorizations.

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

I agree that I 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 mediation for a period of time.

I will bring all 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.

I understand that ANY deviation from the above conditions can be grounds for Dr. Gisi to discharge me from the practice.

This Agreement is entered into on this _____ day of

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Physican: _____

Sylvia A. Gisi, M.D.

Witnessed by: _____