Name:

Date:

North Alabama Bone & Joint Clinic, P.C.
PAIN MANAGEMENT AGREEMENT

The purpose of this **Agreement** is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your physician comply with the law regarding controlled pharmaceuticals.

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

I understand that if I break this **Agreement**, my physician will stop prescribing these pain control medicines. In this case, my physician may taper off 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 physician 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 will not share, sell or trade my medication with anyone.

I will not attempt to obtain any new/additional controlled medicines (including opioid pain medicines, controlled stimulants or antianxiety medicines) from any other physician, unless, I inform the Clinic physician.

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

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 **(Monday through Thursday)**. No refills will be available during evenings or on weekends.

I agree to fully participate in the total care plan prescribed by physician including keeping scheduled appointments and participating in therapies or testing as indicated. By not participating fully in my care plan, I understand that I may be released from the clinic.

Medications are not to be taken for other injuries/problems, ex: sprained ankle, other surgery.

I agree to use _____ pharmacy, located at _____
Telephone number: (_____) - _____- _____ , for filling prescriptions for all my pain medicine.

I authorize the physician 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 physician to provide a copy of this **Agreement** to my pharmacy. I agree to waive any applicable privilege 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 doctor to determine my compliance with my program of pain control medicine.

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 and possible dismissal from the Clinic/care.

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

I agree to follow these guidelines that have been fully understood by me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been give to me.

Patient's signature: _____ **DOB:** _____ **Patient ID:** _____

Witness: _____ **DATE:** _____