The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

Pain Management Agreement

Patient Name: _____ Chart #: _____

I understand, accept, and agree to the following terms and conditions in order to receive care for the treatment of pain at The Spine Center of Southeast Georgia *(place your initials next to each statement)*:

_____ I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain in order to improve my ability to function. Chronic opioid therapy is only one part of my overall pain management plan.

_____ I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

_____ I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating, itchiness of the skin, confusion or other changes in mental state or thinking ability, and problems with coordination or balance. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

_____ I will not seek opioid medications from another physician for the treatment of my pain. Regular follow-up care is required and only my provider will prescribe these medications for my chronic pain for me at scheduled appointments.

_____ I will attend all appointments, treatments and consultations as requested by my providers. I will attend all appointments and follow pain management recommendations.

_____ I will not give or sell my medication to anyone else, including family members, nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. If my medications are stolen, I will report this to police and my provider and will produce a police report of this event if requested to do so.

_____ I understand that if my prescription runs out early for any reason (for example, if I lose the medication or I take more than prescribed), my provider may not prescribe extra medication for me. I may have to wait until the next prescription is due and that my provider will not be available to prescribe medication during evenings and weekends. I understand that my provider will not provide me with refills by phone or at night or on weekends, and that it is my responsibility to call my doctor at least five business days in advance of running out of medications.

_____ I understand that using or attempting to use a forged or falsified prescription will result in the immediate discharge from the practice, and notification of the appropriate law enforcement agencies

_____ I understand that the use of other medications can cause adverse effects or interfere with opioid therapy. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me (tranquilizers), and all illicit drugs.

_____ I agree to periodic unscheduled drug screens.

_____ I understand that I may become physically dependent on opioid medications, which in certain patients may lead to addiction. I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.

_____ I understand that my failure to meet any of the requirements of this agreement may result in my provider choosing to stop writing prescriptions for me. In this case, my doctor may choose to taper my medications over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not deemed to be viable option, I understand that I may be discharged and may be provided with a 30 day supply of medication for use while I find a new physician to provide me with medical care. I understand that withdrawal from medications will be coordinated by my provider and may require specialist referrals.

_____ I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

_____ My providers may obtain information from State controlled substances databases and other prescription monitoring programs. I authorize my providers 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 provider 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.

_____ To the best of my knowledge, I am not pregnant at this time. I understand that opioids are considered dangerous to a fetus. I will do everything possible to avoid getting pregnant while taking these medications unless otherwise approved by my provider.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date