TREATMENT AGREEMENT

Patient Name:_____Date:_____

The purpose of this TREATMENT AGREEMENT is to prevent misunderstandings about our treatment policy.
Please take a moment to carefully read this agreement and place your initials by each of the points listed below.

I want my pain and/or addition treated and I want to actively participate in that regard.

I agree to abide by the following:

1)_____ I understand and agree that I will **use pain medications only as directed**. If there is a concern or question regarding medication I will contact this clinic.

2)_____ I understand and agree that all pain medication prescriptions must be written in the clinic accompanied by an appointment. **No prescriptions will be called in** to a pharmacy.

3)_____ I understand and agree that **I will not receive replacements for lost or stolen medication** or prescriptions.

4)_____ I understand and agree that I will receive pain medications only from this clinic. I give permission to verify that **I am not seeing other doctors for pain medication or pharmacies**. I give permission to contact other health care providers involved in my care to discuss past or future treatment.

5)_____ I understand and agree that I will use a designated pharmacy, or with notification, one of my choosing, each time I fill my pain medication. I am not allowed to switch pharmacies unless I give notification to this clinic. The intent here is to **obtain all my pain medications from one source.**

6)_____ I understand and agree to **submit to urine or blood tests** to detect the use of other medications, substances or other health effects related to taking pain medications whenever this clinic finds it necessary. The intent here is not to have patients private life policed but instead to know what is being prescribed, is being taken, without other pain medications. Pain medications, especially narcotics, are one of the cornerstones of pain management. If this clinic does not know what pain medications a patient is taking then they cannot effectively provide pain management.

7)_____ I understand and agree that if any of the medication prescribed for me **causes drowsiness, sedation, or dizziness, I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy**.

8)_____ I understand and agree that I am asking this clinic to manage my pain and/or addiction by utilizing multiple treatment modalities in the effort to manage my pain. The intent here is optimize functionality, decrease the risk of addiction and opiate induce hyperalgesia, and delay the development of opiate tolerance. To this end **I give prior permission to orchestrate my pain & addiction treatment to include physical therapy, psychological services, injections, and medications.**

9)_____ I understand and agree that this clinic **may find it beneficial to prescribe my pain medications in a liquid mixture**. This mixture will contain pain medication adjusted to the patients needs. When applied**, medication names may be divulged to the patient but dosages may not be.** This approach is intended to wean the patient from narcotics, discourage diversion, identify the lowest level of narcotics needed to control pain, and thus better manage the patients' pain medication use. At any time the patient may be told the dosages by simply asking but also realizing that would nullify this agreement.

10)_____ I understand and **agree with this participation agreement in its entirety**. I also understand that if this agreement is not followed, I will be in Violation of this agreement and all services may be terminated, my prescription may not be refilled, and without my medication increased pain and withdrawals my follow. I also understand that it is my responsibility to keep track of my medications and to have an appointment scheduled in advance for any refills.

Patient Signature: _____ Date: _____

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