CALIFORNIA PAIN CENTER

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The medication(s) that may be incorporated into your treatment plan at California Pain Center are an important part of your care. The purpose of this Pain Management Agreement is to prevent misunderstandings about the medication guidelines for our facility. Please take a moment to carefully read and put your initials by each of the points listed below. We cannot begin your consultation without a completed form. Thank you.

Patient Initials

I will be able to receive treatment only if I abide by the following rules:

_____ I will use the medication only as directed by the physician. If there is a concern or question regarding the dosage, I will first contact the office and receive approval before changing the dosage.

_____ I understand that all prescriptions must be written in the office accompanied by an appointment. No prescriptions will be called in to my pharmacy.

_____ I will not receive replacements for lost or stolen medication or prescriptions.

_____ I will not expect to receive additional medications before the next scheduled visit, even if the prescription runs out.

_____ I will receive controlled medication or mood altering drugs only from the physician named above or from his explicit designees. I give permission for the doctor to verify that I am not seeing other doctors for pain medication or going to other pharmacies. I give permission for the doctor to contact other physicians involved in my care to discuss past or future treatment.

_____ I will use the same pharmacy each time. I am not allowed to switch pharmacies unless given clearance to do so.

_____ I agree to submit to urine or blood tests to detect the use of other medications, substances or other health effects whenever my physician finds it necessary.

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

_____ If it appears to the physician that my daily functioning and quality of life are not improved by the use of controlled medication, I will gradually taper off that medication as prescribed by the physician. I will not hold any member of the treating team responsible for ill effects caused by discontinuation of the controlled medication, provided that I receive 30days notice of termination.

_____ I recognize that my chronic pain is a complex problem that may respond to other measures used in combination with the medication. Such treatments may include physical therapy, psychotherapy, behavioral approaches and counseling. It may require family involvement. I agree to participate actively in all aspects of the pain management program, as directed by my physician.

_____ I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on my medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

_____ I understand the above medication guidelines. I also understand that if these guidelines are not followed, my prescription may not be refilled immediately, and without my medication my pain may increase. I understand that it is my responsibility to keep track of my medication and to have an appointment scheduled in advance for any refills.

_____ I understand that if I violate any of the above rules I may be discharged from my care at California Pain Center.

Patient Signature:_____ Date:_____

Print Name:_____