**Norman J. Dozier, M.D., P.A.**
Board Certified in Pain Management | Board Certified in Anesthesiology

# Pain Management Agreement For Chronic Opiate (Narcotic) Use

**I UNDERSTAND AND AGREE TO THE FOLLOWING:**
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, pain-killers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

**My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:**

Opiate drugs taken with alcohol or street drugs, or in greater doses than prescribed, can cause increased side effects leading to dangerous situations like coma, organ damage, or even death. If you suddenly stop taking an opiate after using it for a long period, you may feel withdrawal symptoms such as sweating, nausea, vomiting, uncontrollable yawning, tearing of the eyes, runny nose, muscle spasms, diarrhea, bone and muscle pains, hot and cold flashes, sleeplessness, etc.

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**

- I will **disclose** to my physician all medication(s) that I take at any time, prescribed by any physician.

- I will use the medication(s) **exactly as directed by my physician**.

- **All medication(s)** must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they will NOT BE REPLACED.**

- Refill(s) **will not be ordered before the scheduled refill date**. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. Please allow 24 hours' notice for refill requests.

- I will receive medication(s) **only from ONE physician** unless it is for an emergency **OR** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has· not been approved by my physician may lead to a discontinuation of medication(s) and treatment. Obtaining narcotic prescriptions from more than one physician at the same time is considered "diversion" and is subject to reporting to the Department of Public Safety and may lead to arrest.

- Medications that are not prescribed for you should not be used. **Do NOT share, sell, or trade** these medications for money, good, or services. **This too is considered "diversion" and is subject to reporting to the Department of Public Safety and may lead to arrest.** Tell your physician if any over-the-counter medications are being used.

- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), **then my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).

**Patient Initials** _____

- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.

- I agree that **I shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

- Physical or verbal threats to health-care providers or the staff may be cause for discontinuation of opiate medication and discharge from this practice.

I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. **I have never** been involved in the sale, illegal possession, misuse/diversion, or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3. **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

Patient Signature

Printed Name

Physician Signature (or Appropriately Authorized Assistant)

Norman J. Dozier, M.D.

David A. Lindley, D.O.

Date