Stevanovic Family Clinic
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PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medications you may be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

- I understand this agreement is essential to the trust and confidence necessary in the doctor/patient relationship and that my doctor will render treatment based on the agreement.
- I understand that if I break this agreement, my doctor will stop prescribing these pain control medications.
- In this case, my doctor will taper off the medication 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 doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication 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 medications with anyone.
- I will not attempt to obtain any controlled medications, including opiates, controlled stimulants or anti-anxiety medications from another doctor.
- I will safeguard my medication from loss or theft. Lost or stolen medications will not be replaced.
- I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.
- I authorize the doctor and my pharmacy to fully cooperate 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 medications.
- I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any special privilege or right of privacy or confidentiality with respect to the authorization.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine compliance with my program of pain control medication.
- I agree that I will use my medication at a rate no greater than prescribed. The use of my medication at a greater rate will result in my being without medication for a period of time and termination of this document and/or treatment from this clinic.

Pharmacy Use

I agree to use_____

Pharmacy Located at_____

Telephone Number_____for filling prescriptions for all pain medicine.

I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered.

A copy of this agreement is entered into on the ___day of _____, _____. (year)

Patient Name: _____