GREENHAVEN
Family Practice

Scarlett Lu D.O.

Pain Management Agreement

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

1. _______ I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement

2. _______ I understand that if I violate this Agreement, my doctor will stop prescribing these controlled medicines.

3. _______ If indicated, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

4. _______ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.

5. _______ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain in my daily life, and how well the medicine is helping to relieve the pain.

6. _______ I will not use any medications not prescribed by my doctor and any illegal substance, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be infrequent and limited to times when I am not driving or operating machinery.

7. _______ I will not share my medication with anyone.

8. _______ I will not attempt to obtain any controlled medications, including opiod pain medications, controlled stimulants, or anti-anxiety medications from any other doctor.

9. _______ I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced.

10. _______ I agree that refills of my prescriptions for pain medications is every 30 days during regular office hours. No refills will be available during evenings or on weekends.

11. _______ I agree to comply with office visits or keep my appointments as recommended by my doctor.

I agree to use: ____
(Name of Pharmacy)

Located at: ____
____

12_______ I authorize the doctor 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 misuse, sale, or other diversion of my controlled medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, primary care physician, and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

13_______ I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

14. _______ I agree that I will use my medicine at a rate no greater than prescribed and that use of my medicine at a greater rate will result in my being without medication for a period of time.

15. _______ I will bring unused controlled medicine to every office visit.

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

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered on this________ day of _____________________ 2014

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Print Patient Name

____

Patient Signature

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Physician Signature