Carolinas Center for Advanced Management of Pain

Pain Management Agreement

PATIENT NAME: _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and the Carolinas Center to comply with the law regarding controlled pharmaceuticals (pain and nerve medicines).

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.

*I understand that if I violate this Agreement **by any of the means mentioned below**, my doctor may stop prescribing these pain-control medicines, discharge me from the practice, and may also inform my referring doctor, medical facilities, and other authorities.*

I understand that use of these medications can lead to physical dependence and withdrawal symptoms will occur if I stop taking these medications without proper supervision.

In the case, my doctor may taper me off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms, or refer me to a drug-dependence treatment program.

Medications are prescribed to decrease pain and improve function and/or ability to work, not simply to feel good. 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 medicine is helping to relieve the pain and increase my activities.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not use alcohol, CBD products, Kratom, etc in conjunction with my pain medication (opioids/narcotics)

I will not share, sell, or trade my medication with anyone, for any reason.

I will not attempt to obtain, or accept, any controlled medicines, including opioid pain medicines, controlled stimulants, and anti-anxiety medicines from anyone, including another doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines may not be replaced.

I agree that I will submit to random blood or urine tests as requested by my doctor to determine my compliance with treatment.

I agree that I will take my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time, and possible withdrawal symptoms.

I will bring all unused medicine to every office visit in the current pill bottle from the pharmacy. **If I do not, this is cause for dismissal.**

I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit during regular office hours. No refills will be available during evenings or on weekends. Running out of medications is not an emergency.

PATIENT NAME: _____

DATE OF BIRTH: _____

I agree to use _____ pharmacy,

Located at _____

Telephone number _____

I authorize Carolinas Center for Advanced Management of Pain and my pharmacy to cooperate fully with and all city, state or federal law enforcement agency, including DHEC, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

I authorize my doctor to provide a copy of the agreement to my pharmacy and any other pharmacy contacted regarding my treatment and further authorize these pharmacies to release information to Carolinas Center for Advance Management of Pain regarding and all controlled substances, which I have received from that pharmacy, regardless of the prescribing physician, during the period of time, that I am a patient at Carolinas Center for Advanced Management of Pain.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations

I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document will be provided to me at my request.

This agreement is entered into on (date) _____

Patient Signature _____

Provider Signature _____