**A picture containing application

Description automatically generated**

**Pain Treatment with Opioid Medications: Patient Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and voluntarily agree that (initial each statement after reviewing):

\_\_\_\_\_ I will keep (and be on time for) all my scheduled appointments with the doctor or other members of the treatment team.

\_\_\_\_\_ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with provider.

\_\_\_\_\_ I will keep medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

\_\_\_\_\_ I will take my medication as instructed. I will not take more pills or take them more frequently than prescribed.

\_\_\_\_\_ I will not sell this medicine or share it with others. I understand that if I do my treatment will be stopped. I will not take anyone else medication.

\_\_\_\_\_ I will tell the doctor all other medicines that I take and let him/her know right away if I have a prescription of new medication.

\_\_\_\_\_ I will participate in all other types of treatment that I am asked to participate in.

\_\_\_\_\_ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

\_\_\_\_\_ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

\_\_\_\_\_ I understand that my doctor or his/her staff will check the state prescription drug database to prevent against overlapping prescriptions.

\_\_\_\_\_ I will use only one (1) pharmacy to get all my medicines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Pharmacy name/phone #

\_\_\_\_\_ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment will be stopped.

\_\_\_\_\_ I will come in for random drug testing and counting of my pills within the same day of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed test will be considered noncompliant, and my treatment will be stopped.

\_\_\_\_ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can’t pay for treatment anymore.

\_\_\_\_\_ I understand that I may lose my right to treatment if I break any part of this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Patient signature Patient name printed Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Witness signature Witness name printed Date**