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 both you and Premier Pain Solutions to comply with the law regarding controlled pharmaceuticals (pain and nerve medicines).

You may or may not receive narcotic medications. If you do receive narcotics, the following agreement will apply:

____ I will obtain all narcotics from ___ _____ pharmacy or ONE pharmacy of your choice. I must notify the pain clinic if I change pharmacies. The name of the pharmacy I use is:_____and the phone number is:_____ .

____ I understand this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and my doctor undertakes it to treat me based on this agreement. The prescribing physician has complete liberty to discuss fully all diagnostic treatment details with the pharmacist dispensing the medication for maintaining accountability.

_____ I understand if I violate this agreement, my doctor may stop prescribing medicines, discharge me from the practice, and may also inform my referring doctor, medical facilities, and other authorities.

_____ Medications are prescribed to decrease pain and improve function/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 life, and how well the medicine is helping to relieve the pain and increase my activities.

____ I will not attempt to obtain, or accept, any controlled medicines, including Opioid pain medicines, or controlled stimulants from anyone, including another doctor.

_____ I understanding the use of these medications will lead to physical dependence and may result in possible addiction and/or death. Withdrawal symptoms will occur if I stop taking these medications without proper supervision. Therefore, I agree to take my medication only as prescribed. Taking more than the prescribed dose will result in me being without medication for a period of time and may possibly result in withdrawal symptoms.

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

____ I will safeguard my pain medication from loss or theft. Lost or stolen medicines WILL NOT be replaced.

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

____ I will abstain from using any alcohol while taking opiate pain medications.

____ I agree to submits to random blood or saliva tests as requested by my doctor to determine my compliance with treatment. Presence of unauthorized substances or absence of authorized substances may result in immediate dismissal from the practice. Refusal of drug screen is automatic dismissal.

____ I will bring all prescription medications prescribed for pain in their original bottles to every office visit.

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____ I understand that I may be called to the office for a count of my medication(s) at any time. I understand that I must present to the pain clinic on the same day called, during office hours, with all my prescribed pain medication(s).

____ I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit (not a procedure day), during regular office hours. No refills will be available during evenings or weekends. **Running out of medications is not an emergency.** Prescriptions are NOT called in to the pharmacy. Renewals are contingent on keeping scheduled appointments. Do NOT call for prescriptions or expect renewals or refills after hours

____ I understand for emergencies occurring after office hours, I will go to my local emergency room.

_____ If you were to not call or not show up for your appointments, you will be rescheduled on the next available clinic day which may be days or weeks out and also could result in but not limited to running out of prescribed medications, which is not an emergency as listed above.

I authorize Premier Pain Solutions and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including DHEC, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

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

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

Missed appointments are difficult to reschedule. If you are unable to keep your appointment, please notify the office 24 hours in advance or prior to the start of business on your appointment day and leave a message. Failure to do so will result in a $50.00 failure to show appointment charge.

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

This agreement is entered into on this _____day of _____, _____ at_____.

Patient Signature: _____

Witnessed by: _____

Copy Given to Patient by:_____ Date:_____