



Patient Pain Management Agreement

Patient Name: _____ DOB: _____

Primary Care Provider: _____

THE PURPOSE OF THIS AGREEMENT IS TO PREVENT MISUNDERSTANDINGS ABOUT CERTAIN MEDICINES YOU WILL BE TAKING WHILE UNDER CARE FOR PAIN MANAGEMENT. THIS IS TO HELP YOU AND YOUR PROVIDER TO COMPLY WITH THE LAW REGARDING CONTROLLED PHARMACEUTICALS.

Patient Initial: _____

_____ I understand that my provider and I will work together to FIND the most appropriate treatment for my chronic pain. Pain medication is only one part of my overall pain management plan.

_____ I agree to attend all SCHEDULED: appointments, treatments, and consultations as requested by my provider. I will attend all pain appointments and FOLLOW pain management recommendations. I understand that if I FAIL to show up to an appointment or treatment for any reason, my prescriptions will be discontinued until I attend another appointment.

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

_____ I understand that if I break this Agreement, my provider will stop prescribing pain medication. If applicable, my provider will implement safe discontinuation of my pain medication. Also, a drug-dependence treatment program may be recommended.

_____ I agree to communicate fully with my provider 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.

_____ I understand that pain medication has the potential to be addictive along with other potential side effects that have been explained to me by my provider.

_____ I will not use any illegal drugs, including marijuana, methamphetamines, cocaine, etc. If I am prescribed to take medical marijuana, I agree to bring my Medical Marijuana Identification Card to my next appointment.

_____ I will not share, sell, or trade my medication with anyone else, including family members; nor will I accept any pain medications from anyone else.

_____ I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. If these medications are stolen, I will report this to the police and my provider and will produce a police report of this event if requested to do so.

_____ I agree that I will use 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. "Running out early" is not an acceptable excuse for early refills.

_____ I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ I understand that PCCC does not accommodate "walk-in" patients, including but not limited to writing refills on medications for: 1) failure to show up to scheduled appointments; 2) showing up late for scheduled appointments; or 3) failure to schedule a next month appointment during a visit.



_____ I will bring all unused pain medicine to every office visit. I agree and understand that my provider reserves the right to perform random or unannounced pill counts of my medication.

_____ I will not attempt to obtain any pain medications from any other prescriber (including prescribers in the emergency department). If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this Agreement. I will then immediately advise my provider at PCCC that I obtained a prescription from another prescriber.

_____ I agree to use one pharmacy for filling prescriptions for all my pain medicine. I understand that PCCC participates in The California Prescription Drug Monitoring Program (PDMP) and will routinely check the Controlled Substance Utilization Review and Evaluation System (CURES) to verify my compliance. I understand I cannot reroute my medication if a pharmacy is out of my medication and will comply with any alternative treatment provided by PCCC.

Pharmacy: _____ **City:** _____ **Phone:** _____

_____ I authorize the provider and my pharmacy to cooperate fully with the 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 medicine. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I understand that I have an **ongoing requirement** to let my provider know if I am on probation, parole, in a court-ordered rehabilitation program, or involved in other legal matters which monitor or prohibit my use of prescription pain medications. I authorize my provider to contact the appropriate legal authority regarding such issues. (Check the appropriate box if applicable : ☐ Probation ☐ Parole ☐ Rehabilitation Program).

I agree and understand that my provider reserves the right to perform random or unannounced urine drug testing, which may be forwarded to a contracted lab for further confirmation as needed. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my provider may change my treatment plan, including safe discontinuation of my pain medications when applicable to complete termination of the provider & patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine as well can be grounds for termination of the provider & patient relationship. Urine drug testing also confirms that I am taking my prescribed medication. Urine drug testing is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

_____ I agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

_____ I agree to attend and participate fully in any other assessments of pain treatment programs which I maybe recommended by the provider at any time.

_____ I understand and agree that I may be dismissed as a patient for disorderly behavior in the clinic and or over the phone with clinic staff. I understand that abusive behavior towards clinic staff, or disruptive behavior interfering with the care of other patients will not be tolerated.

I UNDERSTAND THAT ANY DEVIATION FROM THE ABOVE AGREEMENT MAY BE GROUNDS FOR THE PROVIDER TO STOP PRESCRIBING PAIN MEDICATIONS AT ANY TIME.

Patient Signature

Date