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MEDICATION MANAGEMENT AGREEMENT

This agreement, between ___________________________________ ("Patient") and Pain Partners, MD, is for the purpose of establishing an agreement between doctor and patient on clear conditions for the prescription and use of pain controlling medications prescribed by the doctor for the patient. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the doctor for the patient.

1. I agree that this medication regimen will be continued for a period of weeks to months and that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program. I will have an increase in function but likely not complete relief of my pain. My case will be reviewed throughout treatment and if there is no evidence that progress is being made to achieve these established goals, the regimen will be tapered to my pre-trial medications and my care may be referred to another specialist the doctor deems necessary. __________ **(pt. initial)**
2. I realize that all medications have potential side effects, to include, but not limited to, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, and the possibility of impaired cognitive (mental status) and/or motor ability, and overuse of opioids can cause decreased respiration (breathing). I will us my medications as directed to keep my regimen as safe as possible.___________ **(pt. initial)**
3. If there is any question of impairment of my ability to safely perform any activity, including driving, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days. ________ **(pt. initials)**
4. I will not use any illegal controlled substances, including marijuana, cocaine, etc. If I do, it may result in termination of the doctor/patient relationship. ______________ **(pt. initial)**
5. I understand that patients with a personal or family history of substance abuse, including alcohol abuse, are at high risk for potential addiction and/or relapse from certain medications. I have notified Pain Partners MD of any personal or family history of substance abuse, including alcohol abuse. ______ **(pt. initial)**
6. To ensure patient and public safety, it is the policy of Pain Partners MD to occasionally and randomly perform unannounced urine drug tests on those patients receiving chronic opioid therapy. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with this agreement and my regimen of pain control medication. I understand Pain Partners will be unable to prescribe medications to any patient who refuses such a test no matter what the reason. ______________ **(pt. initial)**
7. I understand if there is questions regarding my urine drug test results, I may only be given 1-2 weeks of medications until the quantitative results are returned from the lab. ______________ **(pt. initial)**
8. I understand that the commission of a misdemeanor or felony may result in termination of our relationship. ________ **(pt. initial)**
9. I will not share, sell, or trade my medication for money, goods or services. ______________ **(pt. initial)**
10. I understand that some of the medications used to treat my pain may be used off or outside of their FDA label. I trust the medical decision of my provider to use such medications and will review any questions or concerns I have with Dr. Boyd or staff of Pain Partners MD.______ **(pt. initial)**
11. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by this office and I understand this is against the law to do so. <u>If instructed, I will discontinue all previously used pain medications.</u> ____________ **(pt. initial)**
12. I will safeguard my medication to prevent loss or theft. I agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time. I agree that stolen medications must be reported to the police and to Pain Partners MD immediately and a police report must be filed. Pain Partners MD may choose not to replace the medications or to taper and discontinue the medications. ______ **(pt. initial)**
13. I agree to use **ONE Pharmacy** ___________________, **located at** ___________________, **telephone number** _________________ for all of my pain medication. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number. I authorize the doctor to provide a copy of the agreement to my pharmacy. _____________ (pt. initial)
14. If there is question in regards to diversion, abuse, or misuse of my medications, I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing and use of my pain medication. I authorize my care provider to contact any health care professional, family member, or pharmacy to obtain or provide information about my care or actions and to cooperate fully with legal authorities or regulatory agencies in the investigation of any possible misuse, sale or other diversion of my pain medications. _____________ **(pt. initial)**
15. I agree that I will use my medication at a frequency no greater than that prescribed and that overuse of my medication may result in my being without medication for a period of time, and could <u>possibly cause my death</u>. A new prescription will not be written due to overuse of medication (as dictated by Federal and Colorado State laws). ______________ **(pt. initial)**

Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (including emergency rooms), unauthorized dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship. The above agreement has been explained to me by my provider and I agree to its terms so that Pain Partners MD can provide quality pain management using opioid therapy to decrease my pain and increase my function.

This agreement is entered into ______________________________ Patient Signature: ____
(Date)
Provider Signature: ______________________________________Witness: ____