PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you, the Patient, will be taking for management of your pain. This is to help both you and your SMH Physician Network Provider comply with the State and Federal laws regarding controlled pharmaceuticals.

I understand this Agreement is essential to maintaining the trust and confidence necessary in a doctor/patient relationship and that my SMH Physician Network Provider undertakes to treat me based on this Agreement. Therefore, I also understand that **if I break this Agreement**, my SMH Physician Network Provider will stop prescribing pain-control medications for me and **I will be terminated as his/her patient and discharged from his/her care.** If that happens, my SMH Physician Network Provider will taper off my medications over a period of several days, as he/she judges necessary to avoid withdrawal symptoms. Also, he/she may recommend me to a drug-dependence program. Throughout the life of this Agreement, I will communicate fully with my SMH Physician Network Provider about the character and intensity of my pain, the effect of the pain on my daily life, and about how well the medicine is helping to relieve my pain.

- **I will not use any illegal substances, including marijuana, cocaine, etc.**
- **I will not share with, sell to, or trade anyone my prescribed medications, or will I use any medications that have been prescribed for any other person.**
- **I will safeguard my pain medicines from loss or theft.** ***I understand that lost or stolen medicines will not be replaced and I will have to wait until the usual refill date arrives before I will be able to refill them.***
- **I understand that refills of my prescriptions for pain medication will be made only at the time of a scheduled office visit. No refills will be available by telephone, in the evenings, or on weekend.**

I agree to use ____ Pharmacy, located at

____, to fill all prescriptions for controlled substances.

The pharmacy telephone number is_____________________________________.

I authorize my SMH Physician Network Provider, any other doctor who may be treating me, and my pharmacy to cooperate fully with any city, state, or Federal law enforcement or administrative agency, including but not limited to the Louisiana Board of Pharmacy, the Louisiana State Medical Board, or the Federal Drug Enforcement Administration, in any investigation into possible misuse, sale, or other diversion of my pain medicine. I authorize my SMH Physician Network Provider to provide a copy of this Agreement to my pharmacy and to any law enforcement or administrative agency. I hereby waive any privilege or right of privacy or confidentiality, whether under Federal HIPPA regulations or otherwise, that might otherwise apply to these authorizations.

I agree to notify my SMH Network Provider of any and all controlled medications prescribed by another physician including but not limited to opioid pain medications, controlled stimulants or anti-anxiety medicine.

I agree that I will submit, within twenty-four (24) hours after notification, to a blood or urine test, if requested by the doctor to determine my compliance with my program of pain control medicine.

I agree I will use my medicine as instructed by the doctor and will use it at a rate no greater than the rate prescribed for me. I will not increase the dosage of medicine I am taking without my SMH Physician Network Provider's permission. I understand that if I use my medicine more frequently or in larger doses than she has prescribed for me, that will results in my running out of medicine before my scheduled refill date and that I will then have to go without further medicine until that refill date arrives.

I agree to follow these guidelines. They have been fully explained to me and I have had the opportunity to ask questions about them that I may have had. All my questions and concerns regarding my treatment have been answered fully and adequately. I have been given a copy of this Agreement.

This Agreement is entered into on this _________________ day of _____________________, 20_____.

Patients Name: ____ Birth Date: ________________

Patient/Parent/Guardian **Signature**: ____ Date: __________________