AUBURN FAMILY HEALTH CENTER, P.C.

Chronic Pain Management & Controlled Substance Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management and other health conditions. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship.

I understand that if I break this Agreement, my provider will stop prescribing these medications. In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my provider about the character and intensity of my condition, the effect this has on my daily life, and how well the medication is helping.

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

I will not share, sell, or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including narcotic pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider or any other source.

I will safeguard my medicine from loss or theft. Lost or stolen medicines will NOT be replaced.

I agree that refills of the following prescriptions will be made every _____ days. Your provider would like you to schedule an office visit to discuss your medication every _____ days. No refills will be available on Friday's, evenings or on weekends; nor will refills be approved prior to your refill date on your prescription.

_____

_____

_____

I agree to use only the pharmacy named below to fill all my medicine.

_____

Pharmacy Name

_____

Address Telephone Number

_____

Patient's Printed Name

I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

Controlled substances (pain, sleep, muscle relaxants, stimulants, anti-depressants) are tracked by the Drug Monitoring Program (PDMP). Pharmacies and Providers DO track your usage of controlled substances through obtaining an online report, which annotates providers who have prescribed, and pharmacies that have dispensed these medications.

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 agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my prescribed medication. I understand that I am financially responsible for this testing.

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 of time. Refills will not be approved prior to your refill date on your prescription.

I will bring all unused pain, anxiety, ADD, sleep aid medicine to every office visit.

If I sign a pain contract from another provider, I will notify my primary care provider, which will then void this agreement.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____day of _____.

_____

Patient Signature | Patient Date of Birth

_____

Physician Signature | Date Signed

_____

Witness Signature

_____

Patient's Printed Name