



CONTROLLED SUBSTANCE / PAIN MANAGEMENT AGREEMENT

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

Provider location: Caswell Family Medical Center, Yanceyville James Austin Health Center, Eden

- **I understand** that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.
- **I understand** that if I break this Agreement, I may be terminated from receiving care at Compassion Health Care, Inc. after 30 days which allows me time to find another provider. I will, however, be seen for emergency (life threatening) conditions that may develop during this 30-day time. In this case, my provider may 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 pain, the effect of the pain on my daily life, and how well medicine is helping to relieve the pain.
- **I will not** use any illegal controlled substances, including marijuana, cocaine, etc.
- **I will** limit my use of alcohol as it may increase the side effects of my pain medicine.
- **I will not** share, sell, or trade my medication with anyone.
- **I will not** attempt to obtain any controlled medicines, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.
- **I will** safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will keep my pain medication out of the reach of children.
- **I agree** to use the following Pharmacy for filling prescriptions for my pain medicine:
Pharmacy Name: _____
City _____ State: _____ Zip: _____ Phone: _____ / _____ / _____
- **I authorize** the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, and to contact any pharmacies in the investigation of any possible misuse, sale, or other diversion of my pain medication.
- **I authorize** my provider access to any State controlled substance registry.
- **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 required by my provider to determine my compliance with my program of pain control medicine.
- **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.
- **I will** bring all unused pain medicine, pain medicine bottles, and all prescription bottles to every office visit.
- **I understand** that for anxiety, the first line therapy is a SSRI. Benzodiazepines are immediate help but are ineffective for chronic therapy and are addictive. Compassion Health Care, Inc. will treat anxiety with an SSRI. If needed, in addition to the SSRI, a benzodiazepine may be prescribed. Regular exercise is also a benefit for anxiety and is encouraged.
- **I agree** to follow these guidelines that have been fully explained to me. All 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 _____, 20_____

Patient Name: _____

Patient Signature: _____

MR #: _____ Date of Birth: ____/____/____

Provider's Signature: _____

Witnessed By: _____