Practice:	Patient Name:
Practice Phone:	Chart #

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement between you and your healthcare provider is to come up with the best plan to treat your pain.

1) I understand that this Agreement is important to the trust needed for my provider and me to work together in controlling my pain.

2) I understand that if I break our Agreement, my provider may stop writing prescriptions for these pain-control medicines. My provider may also recommend a program to help me with possible overuse of, or addiction to, my pain medicine.

3) I agree to follow the whole pain treatment plan. I understand that it may include things like physical therapy, counseling, other medicines, referrals to specialists and/or other ways to treat pain besides pain medicine. If I do not follow the whole plan, my provider may not write an order for my pain medicine.

4) I will be open and honest with my provider about the kind of pain I have and how bad it is. I will let the provider know about the effect of pain on my daily life and how well the medicine is helping the pain.

5) If I am female, I agree to tell my provider right away if I am pregnant or plan to become pregnant. I will schedule an appointment soon as possible if I become pregnant while getting treatment for pain.

6) I will not use illegal drugs, like marijuana, cocaine, etc.

7) I will not use medicine that is not prescribed to me.

8) I will try not to use alcohol. I will let my provider know right away if I do use or will use alcohol. I understand that drinking alcohol is dangerous and may cause overdose.

9) I will not share, sell or trade my medicine with anyone.

10) I will not get extra pain medicine from any other provider without talking to ______________________________ first.

11) I will give my provider a list of <u>all</u> of the medicines I am taking. I will let him/her know if I get a prescription AT ANY TIME for stimulants (like Adderall) or anxiety medicine (like Xanax, Klonopin) <u>BEFORE</u> I fill the prescription.

12) I will make sure my pain medicine is not lost or easily stolen and is kept away from children. *Lost or stolen medicines will not be replaced.*

13) I know that refills of pain medicine will be given only at the time of an office visit or during regular office hours. *No refills will be given after hours, on weekends or on Friday evenings.*

14) I will only use one pharmacy to fill and refill my pain medicine. I will let my doctor know if I change the pharmacy I use.

15) I understand that state law requires that all pain prescription activity by my provider, my pharmacy, and by me is reported to the NC Controlled Substance Reporting System. That system may be reviewed by any provider that takes care of me or by special state agencies that check pain medicine activity.

16) I agree to take blood, urine or other tests if asked by my provider. I will pay for these tests if they are not covered by my insurance. Tests are done to make sure I am taking my pain medicine safely.

17) I agree to random pill counts when asked by my provider.

18) If I choose to take more of my medicine than I am supposed to, I know that I will <u>not</u> be given an early refill. I will be without medicine during that time.

19) I understand that pain medicine may be addictive. If I begin to take more medicine than I am supposed to, I will talk to my provider right away.

20) I will treat everyone in the provider office with respect.

21) I agree to follow this agreement. It has been explained to me and all my questions about care have been answered at this time. We talked about risks of treatment and my treatment plan.

22) If I have a problem following this agreement at any time, I will talk to my provider right away.

This agreement is entered into on this ________ day of ___________, 20______.

______________________	______________________	______________________
Patient Signature	**Printed name**	**Witness**

______________________	______________________
Practice Signature	**Printed name**

This sample Pain Agreement was created by using:

- *CCNC Provider Toolkits*
- *Spindale Family Practice, PA Pain Management Agreement, AAPP*
- *Drug Abuse.GOV (https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf)*

Simplified to approximately an 8th Grade Reading level

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