PAIN MANAGEMENT PHYSICIANS
OF SOUTH FLORIDA

Our goal in the field of Pain Management is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, psychological counseling when needed, and referrals to surgeons or other specialists as required. We strive to manage pain through means other than medications to allow patients to live a relatively pain free life. We seek to treat the cause of the pain and not the symptoms. **However, we also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this agreement is to clarify the conditions under which Pain Management Physicians of S Fl, will prescribe medications for you. This agreement will help you and your doctor comply with the laws regarding controlled pharmaceuticals and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each and every item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS OF ANY AND ALL PRESCRIPTIONS:

1. I will use my medication(s) at a rate no greater than that prescribed by my pain management physician. If I do over-use my medication, that medication will not be refilled early, and I may be without pain medication for some period of time.
2. I will not share, sell, or trade my medication with anyone. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor. I will safeguard my written prescriptions and pain medicine from loss or theft. I understand that lost or stolen written prescriptions or medicines will not be replaced.
3. Sudden discontinuation of a narcotic pain medicine may lead to unpleasant or dangerous withdrawal symptoms.
4. The potential risks and side effects or medications taken for pain, either short term or long terms, can include: drowsiness, nausea, constipation, itching, difficulty with urination, tolerance, dependence, addictions and overdoses
5. In the event that my physician feels that my dose of pain medication is excessive or makes the diagnosis of addiction or overdose, he will reduce the medicine over a period of time (days, weeks, months) as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment or detoxification program may be recommended.
6. I understand and agree that I am not to receive any type of prescription pain medication or sedative medication from any physician other than my pain management physician unless there is a specific medical necessity. Should my caregiver or I receive any pain or sedative medications from other physician, my caregiver or I must inform Pain Management Physicians of S Fl, either by telephone or in writing within 72 hours of having filled the prescriptions.
7. Refills of my prescriptions will be issued only at the time of an office visit, during regular office hours, or immediately following a procedure.
8. Refills will not be available during evenings, on weekends or holidays, and without **at least 48 hours notice** to my physician or his office staff.
9. I understand that it is my responsibility to keep track of my supply of pain medication and to make timely appointments with my doctor to have my prescription(s) refilled. **LAST MINUTE REQUESTS FOR PRESCRIPTION REFILLS ARE NOT WELCOME.**
10. My doctor may, at his discretion, issue a refill or my medication(s) based on a telephone conversation we have regarding my pain condition and the effects that prescribed medications have on this condition

11. I will communicate fully and truthfully with my doctor about the character and intensity of my pain.
12. I have been advised to abstain from or significantly moderate my use of **alcoholic beverages** while taking medication for my pain condition. I will not use any illegal controlled substances, including marijuana, cocaine, heroin, ecstasy, etc. If I am a **cigarette smoker**, I understand that I will be asked to quit. Cigarette smokers typically have a decreased response to pain treatment because of the effects of smoking on oxygen delivery to the peripheral tissues. Additionally, **obesity** is one of the most important causes of failed treatment for chronic pain. Every ten pounds of excess weight that one carries on his/her body results in one hundred pounds of increased pressure on the spine, vertebral discs and spinal nerves.
13. If physical therapy is prescribed, I agree to attend and participate to the fullest extent possible. If there are any problems with my physical therapy, I agree to communicate this to my physician so that he can make the appropriate changes in my therapy program.
14. I agree that I will submit a blood or urine test if requested by Pain Management Physicians of S Fl, to determine my compliance with my regimen of pain medication. Furthermore, at the physician's discretion, the primary caregiver who's signature appears below shall also be subject to periodic urine and/or blood test.
15. If requested, I will bring all unused pain medicine to an office visit for a "pill count." My physician may request additional "pill counts" at any time, and I agree to comply with these requests. I agree that my caregiver or I will bring the most recent prescription container for each medication to each visit with my physician. These containers must correspond to their last prescription recorded in the medical record with the prescription labels intact and legible so that the physician in the medical record may document appropriate control information. Specifically, the prescription registration number and pharmacy telephone number will be noted and verified.
16. I will use only one pharmacy to fill prescriptions for my pain medications. **My pharmacy is (Name): _____ (Phone): _____ Pharmacy location is: _____.** I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's board of pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor 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 further consent to Pain Management Physicians of S Fl, contacting other physicians to discuss prior prescriptions that I have received from those physicians or to obtain the results of diagnostic testing (past or present) in order to obtain adequate information about my condition.
17. I understand that further prescriptions are solely at the discretion of my pain management physician.
18. I further understand that this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement. I understand that if I break this agreement or provide any false information, my doctor will stop prescribing these pain-control medicines and I may be immediately removed from the doctor's care.

I have reviewed all of the items contained in this agreement. I agree to follow all of the guidelines that are described. A copy of this document will be given to me upon request. I voluntarily consent to participation in the pain medication program described in this Agreement.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Caregiver	Caregiver Signature	Date
_____	_____	
Witness (PMPSF representative)	Date	

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