TREATMENT CONSENT AGREEMENT
ACUTE PRESCRIPTION of CONTROLLED SUBSTANCE

My doctor has diagnosed me with Chronic Pain. Chronic Pain is pain that has continued for more then 3-6 months and/or long after the cause for my pain has been fixed. I have been prescribed narcotic pain medicines to treat my pain.

We do not know if long-term use of narcotic pain medicines can result in improvement of pain or in complicating the treatment plan. I also k now that pain medications may not take away all my pain.

We know that addiction to these medications is a risk but at this time we are unable to predict how severe this risk can be. I understand that my doctor may also recommend a gradual reduction in the dosage of the medicines at the right time with the goal of eventually stopping these pain medicines.

I agree to follow ALL of the agreements below:

1. Only my doctor, (Name/Title:_____) will prescribe my narcotic pain medicine(s). I will not ask any other physician or clinician at this clinic or outside this clinic to prescribe my narcotic pain medicine(s).

2. I will fill my narcotic pain medicine(s) at only one pharmacy:

   Pharmacy Name:_____ Ph#_____

3. I will call my doctor named above (Ph# 916-928-0856) if I have any problems with my narcotic pain medicine(s) or find myself with new medical problems.

4. I give permission to my pain doctor to discuss my test results and treatment with pharmacists or other clinicians.

5. **My medications will not be replaced if they are lost, get wet, destroyed or forgotten somewhere.**

6. I will not sell or share my narcotic pain medicine(s) with other persons. I will not get medicines of any kind from other people.

7. I will be the only person using my medications and I will use them as prescribed. I may experience "withdrawal" if I run out of or stop my medications.

8. My clinician may request urine drug screens from time to time. If I have street drugs or drugs in my system that were not prescribed for me, my doctor may refer me for treatment addiction.
9. People with drug problems may want to steal my medications. I will guard my medications carefully. Most commonly family and friends, not strangers, steal medications.

10. I will bring my medications in their bottles to each clinician's visit.

11. These medications can harm someone not familiar to their effects. At home, I will keep my medications in a safe place, out of sight and out of reach of everyone else, especially children.

12. Early refills are not given for any reason. I will not use any more medications than prescribed.

13. If the law asks for my records with a court order (for example: I am using several pharmacies or several clinicians for pain medicine prescriptions), I will no longer have the right to confidentiality.

14. I must keep my appointments in order to receive my pain medication. If I miss an appointment, the clinic cannot guarantee that a make up appointment can be given.

15. I must keep all appointments (physical therapy, specialist clinicians and counselors) that my clinician recommends.

16. I understand these rules and understand that if I do not follow them, my clinician will not be able to continue to prescribe my medications.

Patient Name:_____

Patient Signature:_____ Date:_____

Physician:_____ Date:_____

Witness:_____ Date:_____