NEWPORT ORTHOPEDIC INSTITUTE

Medication Management Agreement

This agreement between the patient _____(print Patient's name) and Pain Management Consultant (Doctor) is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor to the Patient:

- I understand the reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that the medications have potential side effects and adverse reactions and I will have the recommended laboratory studies required to keep the regimen as safe as possible.
- I understand the potential negative side effects of these medications including drowsiness, sedation, dependence, respiratory depression, addiction, constipation, and problems with cognition. I will alert the physician of any of these symptoms immediately if they occur.
- I realize that controlled medications can have life threatening adverse effects if used improperly or not under the specific instructions of the physician. Any improper use of controlled substances without the approval of the supervising physician is subject to review and may lead to breakage of this Doctor and Patient agreement.
- I realize that in order to maintain trust in the doctor-patient agreement, I may be subject to urine drug toxicity screenings at the discretion of the physician.
- I have been advised and understand the dangers of operating an automobile or heavy machinery while under the influence of these medications.
- I understand I should not be consuming alcohol on these medications; any deviance from this understanding must be approved by the physician.
- Early request for refills may not be honored and regular requests for early refills may lead to documentation of non-compliance.
- I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days.
- I will not use any illegal controlled substances, including marijuana, cocaine, amphetamines etc.
- I will not share, sell, or trade my medication for money, goods or services.
- **I will not fill a prescription for pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor**. I understand is it against the law to do so. If another physician (including dentists) prescribes pain medication for me, **the Doctor must approve arrangements prior to filling the prescription for pain medication to verify no duplication.**
- I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.
- I agree to use _____Pharmacy, located at _____, telephone number _____, for all my pain medication. **If I change pharmacies for any reason, I agree to notify the Doctor at the time I receive a prescription**, and advise my new pharmacy of any prior pharmacy's address and telephone number.
- I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible

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misuse, sale or other diversion of my pain medication. I authorize the Doctor to provide a copy of this agreement to the pharmacy.

- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- I understand that this medication regiment will be continued for a period of no more **than 2 months**. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regiment will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

Doctor and Patient agree this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively, and failure of the patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on _____ day of _____, _____.

_____	_____	_____
Patient's signature	Doctor's Name	Witness