YAKIMA MEDICAL CLINIC, PC

COMPLETE FAMILY HEALTH CARE

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Opiate/Pain Management Agreement

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

____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substance.

____ I understand that this agreement is essential to the trust and confidence necessary in provide/patient relationship and that my provider undertakes to treat me based on this agreement.

____ I understand that if I break this agreement, my provider will stop prescribing these pain control medicines.

____ I would also be amendable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

____ 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 the medicine is helping to relieve the pain

____ I will not use any illegal controlled substance, including marijuana, cocaine, etc, nor will I misuse or self-prescribe/medicate with legal controlled substances. Use Of alcohol, will be limited to times when I am not driving or operating machinery and will be infrequent.

____ I will not share my medication with anyone.

____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other providers.

____ I will safeguard my pain medication from loss, theft, or unintentional use by others including youth. Lost or stolen medication will not be replaced.

____ I agree that refills or my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

____ I agree to use this pharmacy _____ Located at this address_____ with the telephone number of _____ for filling my prescriptions for all of my pain medicine.

____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency including this states Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorized my provider to provide a copy of this agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privileges or right of privacy or confidentiality with respect to these authorizations.

____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medication

____ I agree that I may be subject for pill count and or random urine drug screening. I understand that I have 24 hours to complete task. Clinic will send urine requisition to laboratory of choice, or it can be completed at YMC office. No excuses will be accepted by staff, and I am responsible for cost and compliance. Failure to complete task can results in discharge from pain management.

____ I understand that my provider will be verifying that I am receiving controlled substance from only one prescriber and only one pharmacy by checking the PMP website periodically throughout my treatment period.

____ 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 of time.

____ I agree to pick up and store naloxone in a safe place if deemed necessary by my provider.

____ If I am Over 50MED (morphine equivalent doses) I agree to see a pain specialist, if my provider deems it necessary. Or taper my dosage down to a safe MED level.

____ I will bring unused pain medicine to every office visit.

____ I agree to follow these guidelines that have been fully explained to me.

All of 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 _____ year_____

Patient Signature:_____

Name Printed: _____

Provider Signature: _____

Name Printed: _____

Witness by:

Signature:_____

Print: _____