Lancaster Medical
Your Life. Our Specialty

4893 Transit Road | Depew, NY | 716-608-7040
Adult & Family Medicine

Pain Management Contract
Lancaster Medical

1. I, (Patient Name) understand that I am entering into an agreement with my physician to manage my pain with opioid (narcotic) medication. The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by me, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below or consider the initial and/or continued prescription of controlled substances to treat my chronic pain. I have been advised that the purpose of this agreement is to protect my access to controlled substances, protect my doctors ability to prescribe for me, avoid misunderstandings about medications that I will be taking, and to comply with the law regarding narcotics:

2: (Current Medications with Strength) _____

3: The potential side effects of narcotic medications have been explained to me. These include but are not limited to:

* Decreased appetite, constipation
* Increased drowsiness or sleepiness
* Confusion or difficulty thinking
* Balance/coordination problems
* Respiratory depression (breathing too slowly)
* Tolerance (require more medication to get the same effect)
* Physical dependence (abruptly stopping the medication can trigger symptoms of withdrawal)
* Physical dependence of newborns whose mothers take these drugs during pregnancy
* Psychological dependence (stopping the medication may cause you to miss it/crave it).

4. I agree to provide my doctor with a complete and accurate medical history, including my past medical treatment, any other medications I am currently taking, and any history of alcohol or drug addiction or dependency. If I am a female of childbearing age, I agree to inform my doctor immediately if there is a possibility that I may be pregnant.

5. I agree that all controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. I agree to inform my doctor of the identity of all other providers from whom I receive medical treatment. I represent that I currently do not have a problem with substance abuse or dependence. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

6. I agree to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, how the medicine is helping to relieve the pain, and any side effects or problems related to the medication I am taking. I will also inform the office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that I take.

7. I agree to take my medications as prescribed. If I take my medication more often or at a higher dosage than prescribed, I understand that I may be without the medication until the expected renewal date. I understand that these drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

8. I agree that I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medicines from any other health care provider. I agree to inform my doctor if I see another provider in an emergency and receive pain medication.

9. I agree to follow my doctor's instructions about operating heavy machinery, including but not limited to driving a motor vehicle, since these medications can cause increased drowsiness or sleepiness.

10. I agree that I will not use alcohol or any other prescription drugs without my doctor's prior knowledge and agreement. I will not use any illegal controlled substances, including but not limited to marijuana, cocaine, heroin, or other similar substances.

11. I agree that I will not sell, possess illegally, divert or transport any controlled substances. I further agree not to hoard, share, otherwise permit others to have access, sell or trade my medication with any other individual.

12. I agree that I will not alter any of my prescriptions. I understand that if I do so, I will be discharged from the practice immediately.

13. I agree to safeguard my pain medication from loss, theft or damage. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that I will take the highest possible degree of care with my medication and prescription. I should not leave them where others may see them or otherwise have access to them. I understand that if my medications are lost or stolen, they will be replaced at my doctor's discretion and only after a police report has been filed. I agree not to use the medication in any unintended manner. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

14. I agree to keep all my scheduled appointments with my doctor and bring all unused pain medicine with me to every office visit. I understand that if I miss scheduled appointments, my physician may discontinue my medication. If I believe that I need to be seen before my next scheduled appointment, I agree to contact my doctor. Original containers of medications should be brought in to each office visit. Renewals are contingent on keeping scheduled appointments.

15. I agree to participate actively in any additional pain therapies my doctor recommends. If my doctor determines that I have become dependent on controlled substance, I agree to participate in a program for chemical dependency.

16. I agree to submit to a blood or urine test whenever requested by my doctor. Unannounced urine or serum toxicology screens may be requested, and my cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder. If the results reveal that I have failed to comply with this agreement and my treatment plan, I understand that my doctor may elect to decrease or discontinue my medications.

17. I authorize my doctor and his staff to communicate all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care regarding my compliance with this agreement.

18. I further authorize both my physician(s) and my pharmacist to cooperate fully with any city, county, state or federal law enforcement agencies, the New York State Board of Pharmacy, the Bureau of Controlled Substances, any legal authority, and the federal Drug Enforcement Agency in the investigation of any possible misuse, sale or diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to any of these agencies and to my pharmacy. I understand that I waive any applicable privilege(s), right of privacy or confidentiality concerning my treatment and requests for my protected health information from these agencies.

19. Medication refills will be given at office visits only. Medications will only be prescribed for a 30 day supply. Refills will NOT be made outside of an office visit unless my doctor determines in his/her sole discretion that extraordinary circumstances justify an emergency refill outside of regular office hours. I am aware that I must call at least 24 hours before I need my prescription refilled to schedule an appointment.

Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

20. I agree that failure to adhere to these policies may result in cessation of treatment with controlled substances prescribing by all providers at Lancaster Medical or referral for further speciality assessment.

21. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

22. The risks and potential benefits of these therapies are explained elsewhere (and I acknowledge that I have received such explanation).

23. I agree that all controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that I have selected to use is (***Pharmacy Name***), located at (***Pharmacy Address***), telephone number (***Pharmacy Telephone #***), to fill prescriptions for all my pain medicine.

24. I understand that my compliance with the terms of this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor's treatment will be based on this agreement. Failure to comply with all of the conditions in this agreement may result in:

* Danger to my life and health
* My doctor electing to decrease or discontinue prescribing these medications. If this occurs, my doctor may choose to taper the medicine over a period of several days, to avoid withdrawal symptoms when discontinuing it.
* Discharge from my doctor's practice.

25. The terms and conditions of this agreement have been fully explained to me. All of my questions and concerns regarding both my treatment and this agreement have been answered to my satisfaction. I have been given a copy of this document.

I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

This Agreement is entered into on: (***Date***) _____

Patient signature: _____

Physician signature: _____

Witnessed by: _____