Chronic Pain Agreement

I, _____*(patient receiving chronic **pain** medications*), have agreed to correctly use pain medications as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase my level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____will be my pain management provider and the only provider who will be ordering my pain medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

_____ I will only take the medications at the amount and frequency as ordered.
_____ I will not increase or change how I take my medications without the approval of my pain management provider.
_____ I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours. I will make the necessary arrangements before holidays and weekends.
_____ I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

Pharmacy: _____ Phone Number: _____

_____ I will allow my pain management provider to provide a copy of this agreement to my pharmacy.
_____ I will not ask for any pain medications or controlled substances from other providers and will let my my pain management provider know of all medications I am taking, including non-legal drugs.
_____ I understand that other physicians should not change doses of my pain medications without first talking to my pain management provider.
_____ I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.
_____ I will let my other health care providers know that I am taking these pain medications and that I have a pain management contract.
_____ In event of an emergency, I will give this same information to emergency department providers.
_____ I will allow my pain management provider to discuss all my medical conditions c and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.
_____ I will inform my pain management provider of any new medications or medical conditions.
_____ I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
_____ I will keep medications only for my own use and will not share them others. I will keep all medications away from children.
_____ In addition, I will do the following (Initial each box):

_____ I must make an appointment with a drug and alcohol counselor and bring proof on working with my treatment plan. (contact number 1 800 562 1240)
_____ I must take a drug test at (frequency of) _____
_____ I agree to pill counts to prove I am using my medications correctly
_____ If I fail a drug test I will take the drug test more often at _____
_____ If I fail a drug testing I will be referred to the Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (http://maa.dshs.wa.gov/PRR)
_____ If I sell my narcotics my name will be referred to the DSHS fraud unit
_____ If I fail all of the above I will be discharged from your care with no notice

Should any of the above not show good faith efforts and your provider's feel they can no longer ordered your pain medications in a safe and effective you may be notified of discharged from our care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and / or changes in my providers.

Provider: _____Clinic: _____Phone Number: _____
Provider: _____Clinic: _____Phone Number: _____

Patient Signature _____