

MIDWEST PAIN CENTER

Patient's Name: _____
Agreement

Patient Treatment

Chronic pain is a condition that can affect the “quality of life” for many people. At Midwest Pain Center, we are committed to treat your chronic pain condition. Opioid use is regulated by the state and federal agencies. This contract is a tool to establish guidelines, with the law, for proper and controlled opioid use. By signing this contract you agree to use your opioid prescription(s) within these explicate parameters and understand that **any violation of the contract will prevent any further use of opioids in your treatment.**

- I understand the importance of taking **personal responsibility** in the management of my pain, and the **legal responsibility** both federally and in the state of taking opioids appropriately (as prescribed) and not abusing the medication(s).
- I am responsible for my own prescription(s) and am aware that lost, stolen, eaten, etc. prescription(s) will not be replaced. **NO EXCEPTIONS.**
- I will take the medicine as prescribed, and follow my pain response. If I feel that my prescribed pain medication is not working, I agree to contact your office immediately. **I will not increase** my own dosage and/or frequency. I will not give, share, sell, etc. my opiates to friends, relatives, etc. **Periodic drug testing will be utilized. All results will be forwarded to your Primary Care Physician.**
- It is my responsibility to obtain my refill prescription Monday thru Friday between the hours of 8:00a.m. and 3:00p.m. **No refills** will be given on weekends or after business hours. I also understand that I am responsible for notifying you **TWO (2) days** prior to needing my prescription refilled. My failure to notify you may result in delay of receiving my refill.
- Follow-up appointments every 90 days or as directed are **MANDATORY PRIOR** to obtaining opiate prescription(s). **NO EXCEPTIONS.**
- If an opiate trial is unsuccessful, the **remaining drug(s)** must be turned into Midwest Pain Center **prior** to filling a new prescription. **NO EXCEPTIONS.**
- I understand that Dr. Smith is putting himself at risk for loss of his medical license and/or federal and state prosecution. Therefore the policy is **ONE PHARMACY** and **ONE DOCTOR**. I will **only fill** prescriptions at _____, phone # _____. Any changes need to be reported immediately.
- **Violation** of any of these rules means you have forfeited the right for opioid treatment at Midwest Pain Center.

Therefore, I understand that the treatment of pain is multidimensional and I will be compliant with both medical and other forms of therapy, **including psychiatric care** if deemed necessary by Dr. Smith or I will forfeit my right to be treated at Midwest Pain Center.

Signature: _____

Date: _____