NEUROLOGY OFFICE

JOSEPH KANDEL, M.D.

& ASSOCIATES

PAIN MANAGEMENT AGREEMENT

This agreement is being undertaken between_____(the patient) and Neurology Office, Joseph Kandel MD & Associates to define the responsibilities of the patient regarding treatment of a pain problem using opioid analgesics. The patient agrees to the following conditions defining their responsibilities as the patient in this treatment.

1. The patient agrees that this treatment has been explained in terms of its purpose side effects or medication and risks of treatment.
2. The patient understands:
    a. Common side effects of opioid therapy include, but are not limited to, nausea, constipation, sweating and itchiness of the skin.
    b. There is potential for drowsiness and slowed or fuzzy thinking from the opioid therapy both when the medication is started and when the dose is increased. This drowsiness may be more pronounced when sedative medications are taken at the same time. The patient agrees to refrain from driving a motor vehicle or operating dangerous machinery until drowsiness disappears.
    c. There is a low, but definite risk of addiction as a result of this treatment.
    d. Physical dependence may develop to the opioid medication; this means the body may get used to the medication such that a sudden decrease or discontinuation of the medication will result in symptoms of withdrawal. The patient understands that this withdrawal is uncomfortable but is not life threatening.
    e. Children of female patients born when the mother is receiving opioid medication will likely be physically dependent at birth.
3. The patient agrees to attend scheduled appointments with their doctors for monitoring the treatment. The patient further understands that he or she must have a face to face appointment with their doctor every 90 days or will loose their prescription rights immediately.
4. The patient agrees to attend appointments made by the doctor with other health care providers for investigation, treating and consulting purposes and to participate in any chronic pain treatment modalities recommended by the doctor.
5. The patient agrees to open communication with the doctor and with other health care professional such as a pharmacist and other doctors, emergency departments, etc. The patient agrees to inform other health care providers that he or she is being prescribed opioid medication by their doctor as part of a pain management program.
6. The patient consents to the doctor communicating with all other health care providers who are involved in their medical care.
7. The patient agrees to take the opioid medication at the dose and frequency prescribed by the doctor. The patient agrees **not to change the dosage or frequency of the opioid medication without first consulting the doctor.**

Patient Initials:_____ DOB:_____

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8. The patient understands that the opioid medication is a potentially dangerous substance, and that if it gets into the wrong hands, such as a child; it can seriously harm or kill someone. The patient agrees to keep the opioid medication in a safe and secure place to protect against loss or theft and that **lost, damaged or stolen medication/prescription will not be replaced until the next regular scheduled visit. Stolen medication/prescription will not be replaced without first notifying the police and obtaining copy of the police report.**
9. The patient understands that refills for opioid medications will be made only at the time of an office visit or during regular business hours. **No refills will be available during the evenings or weekends. The patient also understands that refill requests to the office require a 72 hour advance notice and that if a shorter notice is given, the office may not be able to accommodate the request. The patient further understands that he or she will not receive early refills or refills picked up by a third party.**
10. The patient agrees not to sell, lend or in any way provide their opioid medication to any other person.
11. The patient agrees not to obtain, seek or use any pain medication or mood altering medication from any physician without first discussing it with the treating doctor.
12. The patient agrees not to use illegal street drugs, such as cannabis, cocaine, heroin or hallucinogens, or abuse alcohol while taking opioid medications.
13. The patient agrees to submit to random urine drug screening at the request of the doctor.
14. The patient agrees to use only one pharmacy for the dispensing of their opioid medications.
15. The patient certifies that she is not pregnant and will use appropriate measures to prevent pregnancies during the course of their treatment with opioid medications.

I understand that if I break this agreement, my physician will stop prescribing these controlled medicines and I may be discharged immediately from the physician's care, as well as the practice.

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.

Signature_____ Date_____

Name(Printed)_____ DOB_____

Physician Signature_____ Date_____