Buckhead Injury Wellness Institute

DOCTOR / PATIENT / PAIN MANAGEMENT AGREEMENT

This agreement between_____ (Patient), Buckhead Injury Wellness Institute (the Center), and _____ (Doctor) is for the purpose of establishing the conditions required for the use of Opiate/Narcotic medications that the Doctor may prescribe for the patient. The Doctor and the Patient agree that this agreement is an essential factor in maintaining a proper Doctor/Patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient.

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- I realize that all narcotic medications have potential side effects. In addition to analgesia, narcotics may produce dependency, addiction, respirator depression, drowsiness, changes in mood, anxiety, and mental clouding. I will report any such side effects to the physician immediately.
- In the event of a need to discontinue taking these medications, I will consult with the Doctor and strictly follow Him or Her instructions for the safe tapering off my medication. Failure to do so may result in severe withdrawal effects and possible even death. I understand that even with the tapering process there may be some discomfort or withdrawal effects.
- I understand the risks, side effects, and benefits of these medications and they have been discussed with me in detail.
- Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform any such activity until my ability to perform the activity has been evaluated.
- I have been informed that I should not take other drugs such as tranquilizers, sedatives or antihistamines without consulting with my physician. I should not use alcohol. The combination of the above drugs, alcohol and/or opiates may produce dangerously profound effects such as sedation, respiratory depression and a decrease in blood pressure.
- I will not attempt to get pain medications from any other healthcare provider Emergency room doctor, Urgent Care or Dentist without telling them that I am taking pain medications prescribed by a doctor. I understand that it is against the law to do so and may lead to the discontinuation of my medical treatment at this facility or may lead to a change in my treatment plan.
- I will not ask to have any prescriptions called in.
- I will not use any illegal controlled substances, including marijuana or cocaine.
- I agree to pill counts as well as urine and blood tests to assess my compliance.
- I will not share, sell or trade my medication for money, goods, or services.
- I will safeguard my medication from loss or theft. I will not lose my prescription; I will not spill or misplace my prescribed medication, or I will be left without prescribed medication until my next visit.
- I am responsible for taking the medication in the dose prescribed, and I will not raise the dosage without the doctor's prior approval. Doing so can cause an overdose or lead to my running out of mediation early.
- Follow-up visits will be scheduled no earlier than 21 days and no later than 30 days and are required for the management of the medication. Refills will be prescribed only on this scheduled basis and will not be called in over the phone.
- I understand that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. I understand that children born while the mother is on Opiate therapy would likely be physically dependent at birth.
- In the event of an investigation, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Doctor to fully cooperate with any City, State or Federal law enforcement agency, including the Georgia Board of Pharmacy; in the investigation of any possible misuse, sale or other diversion of my pain medication.
- Should this office feel that I might be doing harm to another or myself, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication and/or mental state.
- If I am or ever have been on probation, or arrested for a narcotic-related offense, I understand I MUST DISCLOSE THIS INFORMATION AT ONCE**. Check all that applies: Arrested Convicted Probation Parole**
  When _____ Why _____

Doctor and Patient agree that this agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure by the Patient to abide by the terms of the Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into on the_____ day of_____._____ and does **NOT** guarantee a prescription for medication, DME or surgery.
(Day) (Month) (Year)

My signature below acknowledges my understanding and agreement with the above stated terms and my office.

Patient Name	Patient Signature
Doctor Signature	Witness Signature