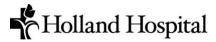


PAIN MANAGEMENT

Pain Management Agreement

Patient:	Date of Birth.:
I understand, accept, and agree to the follow Management office (place your initials next	wing terms and conditions in order to receive care for the treatment of pain at Lakeshore Health Partners Pain to each statement):
	Il work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment y relieve my pain in order to improve my ability to function. Chronic opioid therapy may be only one part of my
agree to take the medication at the dose	Il continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I e and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and erious harm and cause my provider to choose to stop treatment with opioids.
	e effects of opioid therapy include constipation, nausea, sweating, itchiness of the skin, confusion or other change roblems with coordination or balance. I agree to refrain from driving a motor vehicle or operating dangerous ears.
	another physician for the treatment of my pain. Regular follow up care is required and only my provider will onic pain at our scheduled appointments.
I will attend all appointments, treatmen	nts and consultations as requested by my provider and follow pain management recommendations.
	anyone else, including family members, nor will I accept any opioid medications from anyone else. I agree to be y medication at all times. If my medications are stolen, I understand that no new medications will be provided unti
I understand that if my prescription run not prescribe an early renewal.	ns out early for any reason (for example, if I lose the medication or I take more than prescribed), my provider will
I understand that using or attempting the appropriate law enforcement agenci	to use a forged or falsified prescription will result in the immediate discharge from the practice and notification of ies.
interfere with opioid therapy. Therefore,	dications in conjunction with opiates can cause adverse effects (including serious physical harm and even death) on I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not ailure to do so will result in the cessation of opioid prescriptions.
	cally dependent upon opioid medications, which in certain patients may lead to addiction. I agree that if ion specialists as a condition of my treatment plan.
seeking medication. I understand that it is a problem. This also means that I will prescriptions due for refill over the week are not at the pharmacy. Furthermore, I understand that if I miss my follow up a	provide me with refills by phone or at night or on weekends. I will not call the after hour's emergency number is my responsibility to call my doctor at least five business days in advance of running out of medications if there call the pharmacy to ensure any prescriptions due for refill will be available prior to the date of refill, especially kend. I understand that I cannot call after hours or on the weekends about medications that, for whatever reasons I am responsible for ensuring that I have an appropriate follow up appointment for receiving my refills. I ppointment, no further medication renewals will be provided until I am seen in follow up. I understand that failure t medication for a significant period of time which may result in untreated pain and even withdrawal symptoms.
receiving opiates. Failure on my part to I I understand that if a drug screen is pos	screens. I understand that I may be asked to provide a urine sample at any time during my treatment while provide a sample within 24 hours of the request will result in the discontinuation of opiate prescriptions. itive for illegal substances, substances not disclosed to my provider or negative for prescribed medications, ediately. I also understand that there will be no discussions, debates or opportunities for re-sampling if the drug



PAIN MANAGEMENT

	his agreement may result in my provider choosing to stop writing prescriptions for me.
	a period of several days, as necessary, to avoid withdrawal symptoms. If this is not ged and provided with a 30 day supply of medication for use while I find a new
referrals. I understand that there may also be instances in which m	drawal from medications will be coordinated by my provider and may require specialist by provider may decide not to provide any further prescriptions for opiates (this will lates or if there are illegal substances in my drug screen that may give my provider
I hereby agree that my provider has the authority to discuss my provider is deemed medically necessary in the provider's judgment.	pain management with other health care professionals and my family members when it
and my pharmacy to cooperate fully with any city, state or federal	ances databases and other prescription monitoring programs. I authorize my providers law enforcement agency, including this state's Board of Pharmacy, in the investigation e. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree ity with respect to these authorizations.
o the best of my knowledge, I am not pregnant at this time. I und to avoid getting pregnant while taking these medications unless of	derstand that opioids are considered dangerous to a fetus. I will do everything possible therwise approved by my provider.
Physician's Signature:	Date: