Pain Management Agreement

Please read carefully, complete the fields below, and sign.

This agreement is between me and Southwest Ohio Pain Institute regarding the use of controlled substances to treat my pain. I understand and agree to the following terms:

- ☐ 1. I will take my medication only as prescribed and will not change the dose without talking to my provider first.
- ☐ 2. I will use one pharmacy, which I will name below, to fill all my controlled substance prescriptions.
- ☐ 3. I will not obtain controlled substances from any other provider without informing my SWOPI provider.
- ☐ 4. I understand random urine drug screens and pill counts may be required, and I agree to comply.
- ☐ 5. I will safeguard my medication. Lost, stolen, or destroyed medication will not automatically be replaced early.
- ☐ 6. I will not share, sell, or trade my medication with anyone else.
- ☐ 7. I understand early refills are given only at my provider's discretion and are not guaranteed.
- ☐ 8. I agree to attend appointments as scheduled and understand missed appointments may affect refills.
- ☐ 9. I understand this agreement can be ended by SWOPI if I do not follow these terms, and that violating this agreement can result in discharge from the practice.
- ☐ 10. I give SWOPI permission to discuss my treatment with other providers, my pharmacy, and, if needed, law enforcement, for my safety.

PHARMACY OF RECORD

Pharmacy Name

Pharmacy Phone

ACKNOWLEDGEMENT & SIGNATURE

I have read this agreement, had the opportunity to ask questions, and agree to follow these terms as a condition of receiving controlled substance treatment at Southwest Ohio Pain Institute.

Patient Signature (type full name)

Date

Witness Signature (type full name)

Date