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Fellowship-trained in Pain Management
Double Board Certified in
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OPIOID TREATMENT AGREEMENT

- I agree to take my medication as directed.
- I understand that my medication will not be refilled prior to my next scheduled appointment.
- I understand that my medication may cause side effects and that I must notify my physician if any of the following occur: sedation, incoordination, or loss of motor skills.
- I understand that it is not advisable to drive or operate heavy machinery while taking pain medication.
- I understand that I must keep my medication in a safe location and that lost or stolen prescriptions will not be replaced.
- I understand that some medications may be habit forming or addictive. If I develop intense cravings, medication induced "high," or other psychological effects, I will immediately notify my physician and seek medication attention.
- I agree that I will not use alcohol, illegal substances, or any other substances/medication that are not prescribed to me.
- I agree that I will not sell or give my medications to another individual for any reason.
- I understand that if another physician prescribes me any controlled substances, I must notify my pain management physician immediately.
- I agree that I will not be seen or treated by any other pain management physician(s) including, but not limited to, Pain Care Consultants (Drs. Nelson, Letchuman, and Majors), LA Pain Physicians (Dr. Whyte), WK River Cities Interventional Pain (Drs. Noles and Hirsch), Dr. Brewer, or Dr. Tanga.
- I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists and other healthcare professionals for the purpose of maintaining accountability.
- I agree to and will comply with random drug screens and pill counts at my physician's discretion.
- I understand that failure to comply with these terms may result in lost privileges for prescription pain medication and/or dismissal from the practice.

I understand that I have signed an opioid treatment agreement and I agree to the conditions contained therein.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____