
(Pain Treatment with Opioid Medications: Patient Agreement*)

I, _____, understand and voluntarily agree that (initial each statement after reviewing):

_____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medication safe, secure and out of the reach of children. If the medication is lost or stolen, I understand it will not be replaced until my next appointment and may not be replace at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatments team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully always. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____ I will tell the doctor all other medications that's I take and let him/her know right away if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all my medications:

pharmacy name

phone number

_____ I will not get any opioid pain medications or other medicines that can be addictive such as benzodiazepines (klonopin, Xanax, valim) or stimulants (Ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.



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- _____ I will not use illegal drugs such as heroin, cocaine, marijuana or amphetamines. I understand that if I do, my treatment may be stopped.
- _____ I will come in for drug testing and counting of my pills within twenty-four (24) hours of being called. I understand that I must make sure the office has current contact information to reach me, and that any missed tests will be considered positive for drugs.
- _____ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment again.
- _____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at Oklahoma Pain Treatment Centers, are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off the medications that are causing you problems safely, without getting sick.

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| Patient signature | Patient name (printed) | Date |
| Provider signature | Provider name (printed) | Date |