Name of Patient

PRESCRIPTION MEDICATION AGREEMENT FOR
CONTROLLED SUBSTANCE TREATMENT OF PAIN

Nevada law requires a patient to enter into a “Prescription Medication Agreement” if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities of which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please initial within each numbered paragraph and sign below to indicate your understanding of all parts of this document.)

Regarding my treatment plan and the goals of the treatment of my pain, including the appropriate use of a controlled substance.

I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. My practitioner has discussed possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that continuation of a controlled substance for more than 30 days may provide some benefit for the treatment of my pain.

I understand that part of the goals of my pain management therapy may be to minimize or even to discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend tapering or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means; the presence or development of side effects; any signs of misuse, abuse, diversion, or addiction; refusal to comply with diagnostic studies or other aspects of the treatment plan; attempts to obtain medication from other providers; use of illicit drugs or other medications that may interact with the controlled substance; or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.

I hereby reaffirm my consent to monitor my drug use when my practitioner deems it appropriate or necessary, including, without limitations, urine, hair, and blood testing as well as bringing my medications to the prescriber’s office where the number of pills may be counted.

I reaffirm that I will take the prescribed controlled substance only as prescribed.

I will not share my medication with any other person.
____ I agree to inform my practitioner of any other controlled substance prescribed to me or taken by me.

____ I will immediately disclose to my practitioner of any alcohol consumed by me and of any marijuana products, including cannabinoids, I may use or consume while taking the controlled substance for the treatment of my pain.

____ I will disclose to my practitioner whether I have been treated for side effects or complication relating to the use of the controlled substance, including whether I have experienced an overdose.

____ I understand that Nevada state law requires me to provide a listing of every State in which I have previously resided or had a prescription for a controlled substance filled. Below is a listing of such states:

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____ I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children, and I will dispose of unused medication appropriately.

____ I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, tolerance, dependence, and addiction.

____ I understand that prescriptions will only be provided during scheduled office visits, and it is my responsibility to make sure that I have scheduled an appointment for refills (typically 30 days in advance).

____ I understand that my medication is my responsibility and if it is lost or stolen, the medication may not be replaced until my next appointment, at the judgment of my prescriber.

____ If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk for abuse,
dependency and addiction using validated tests. I agree to cooperate for those tests. I understand I will also be required to undergo appropriate testing to determine an evidence-based diagnosis for the cause of my pain. My practitioner may also refer me to a specialist for consultation or for further treatment.

I hereby authorize my practitioner to obtain records from other practitioners or clinics, and speak to other practitioners about my current or prior medical care.

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_____ It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.

_____ I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies investigation, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Occupational Licensing Boards.

I agree to fill my prescriptions from only one pharmacy, unless the medication is not available at that pharmacy or the costs of the medication are substantially better at another pharmacy. I will immediately notify my practitioner if I change or use another pharmacy.

My current pharmacy is:

                                                                                       Pharmacy Phone Number

Pharmacy Name                                                                                  

Pharmacy Address                                                                               

I understand that if I violate any part of this agreement, I may be denied prescriptions for controlled substances and I may be discharged from the clinic.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of this Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain.

Patient Signature                    Patient name printed                    Date

Parent/Guardian                      Parent/Guardian name printed          Date