PAIN MANAGEMENT AGREEMENT

Pain management agreement between ____________________________________ (patient)

and Las Vegas Neuroscience and Paine Medicine Institute.

The purpose of this agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management. This is to help both the patient and their provider comply with the law regarding controlled medications.

I have been informed and understand the policies regarding the use of controlled substance that are followed by the staff at Las Vegas Neuroscience and Pain Medicine Institute. I understand that I will be provided controlled substance while actively participating in this program only if I adhere to the following conditions:

(Please initial each statement acknowledging you have read and agreed to each condition.)

___ I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to completely eliminate pain but to control my pain in order to improve my ability to function. Chronic opioid therapy is only **ONE** part of my overall pain management plan.

___ I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the **DOSE** and **FREQUENCY** prescribed by my provider. I agree not to increase the dose of my opioids on my own and understand that doing so may result in discontinuation of opioid therapy.

___I will attend all appointments, treatments, and consultations as requested by my provider, as well as follow all pain management recommendations. I understand that failure to keep appointments may result in discontinuation of treatment.

___ I will tell my provider about the level and description of my pain in my daily life and how well the medicine is helping to relieve my pain.

___ I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition.

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___If treatment for my condition is available; I agree I will not refuse the treatment just so the opioids will be continued. I understand that I have the right to refuse any procedure, however in doing so my provider is not obligated to continue to prescribe narcotic or opioid medications.

__ The risks and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgments and affect reflexes and motor skills. I will not participate in activities that would endanger myself or others while using these medications.

___I agree I will not use any illegal controlled substances including cocaine, heroin, meth, etc. I agree I will not use any prescription medication obtained illegally, or obtain them from friends or relatives.

___I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.

___I agree I will not share, trade, or sell my medication with anyone.

___ I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will repot stolen medication to the police and to my provider and will produce a police report in this event.

___ I agree I will not attempt to obtain opioid medicines from another doctor or provider without informing my doctor at Las Vegas Neuroscience and Pain Medicine Institute first.

___ I agree that refills of my prescriptions for pain will be made at the time of an office visit only. No routine refills will be available during evenings, after 4 pm, weekends, holidays, or through the emergency room. Medications will not be refilled without being seen on a monthly basis.

___I am responsible for keeping track of the amount of medications left and plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of my medications.

___I agree to bring in all unused pain medication when requested.

___I will submit urine for drug testing if requested by my provider to determine my compliance with their program of pain control.

___ I authorize Las Vegas Neuroscience and Pain Medicine to cooperate fully with any official, including the State Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.

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___ I will accept generic brands of my prescription medications.

___ I understand that I may become tolerant to, addicted to, or have complications from the opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will permit referrals to addiction specialists.

___ If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician.

___I understand that if I violate any of the conditions, my provider may choose to stop writing opioid prescriptions for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals.

___ I understand that if **I am verbally or physically abusive to any staff member** or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police department, drug enforcement agencies, etc. as deemed appropriate for the institution.

___I understand that suddenly stopping some pain medicines can cause problems such as:

- Withdrawal symptoms
- Heart Attack
- Stroke
- Seizures
- Permanent damage
- Disability or death

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All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me upon my request.

By signing below I indicate that I understand AND agree to ALL of the terms of the above agreement.

Patient Name:_____________________________________ DOB:__________________________

Patient Signature:____ Date:_________________

Doctor Mouchir Harb: ____