Painlogics
Mobility. Simplified. Enhanced.

Patient Management and Treatment Agreement

This agreement is between (Patient Name) _____ and Painlogics, LLC for the purpose of establishing an agreement between the physician and the patient regarding treatment of pain conditions. These treatments may range from a variety of physical and behavioral modalities, medications, diagnostic and therapeutic interventions, and alternative treatments. The goals of these treatments, and the efforts of the team, are to improve overall mobility and quality of life. The agreement is unique to the field of pain medicine, and it is necessary in maintaining a basis of understanding needed for the patient-physician relationship.

To establish a patient-physician relationship, I agree and accept the following:

1. This agreement is important to my doctor's ability to treat my pain, and inability to comply with the agreement may result in the discontinuation of prescribed medication and termination of the patient-physician relationship.
2. I understand that the goal of treatment is to improve my ability to function and work. In consideration of that goal, I agree to help myself by following better health habits, especially to encourage better mobility. I must also comply with the treatment plan as prescribed by my doctor.
    - I agree that continued treatment and/or refill of medications may depend upon my compliance with other pain treatment modalities recommended by my doctor.
3. I give permission to allow sharing of medical history with other health care agencies.
    - I authorize my physician to provide a copy of this agreement to pharmacies and other healthcare providers upon request.
    - Doctors, pharmacies, and insurers must cooperate fully with state or federal investigations with regards to possible misuse or diversion of pain medication, as required by law.

I agree and accept the following with regards to medications:

4. I understand that medication regimens may be continued for a finite period of time, if there is no evidence of improvement or progress. Unless medications are used to improve or maintain a reasonable level of function or quality of life, the regimen might be tapered or discontinued.
5. I understand that medications such as opioids and other controlled substances, if deemed beneficial, may be prescribed to me for pain relief. I understand that there are potential risks and side effects involved with such medications, including addiction. Overdose of opioid medication may cause serious injury or death. Other possible complications include constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased

testosterone from chronic opioid use. Some side effects from long-term use may still be unknown.

- I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I stop or decrease the dose, I could have withdrawal symptoms such as nausea, vomiting, diarrhea, aches, sweats, chills, that may occur within 24-48 hours of the last dose.
- I will inform the office of any adverse effects that I experience. I understand that medications may be changed due to the side effects that I am experiencing.
- If female in child-bearing age, I understand that if I am pregnant or become pregnant while taking opioid medications, my child can become physically dependent. Fetal opioid withdrawal can be life threatening. Other medications could cause serious harm or birth defects. As the risks are significant, I will use and discuss the appropriate contraceptive measures during the course of treatment involving opioid medications.
- I realize that it is my responsibility to keep others and myself from harm, especially during driving and the operation of machinery. If there is any question of safety, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve.

6. I agree that I will use my medication at a frequency no greater than prescribed.
   - I will not alter my medications or use in any other way other than it was prescribed.
   - I will not share, sell, or trade my medications or exchange medications for money, goods or services.
7. I will not discontinue any medication that I take regularly without consulting my physician.
   - I will discontinue all previously prescribed pain medications, unless explicitly told by my physician.
   - I must inform my doctor before taking newly prescribed sleeping medications. I understand that the combined use of various medications, opioids, as well as alcohol, may cause confusion, profound sedation, respiratory depression, drop in blood pressure, and even death.
8. I will not attempt or obtain pain medication from any other health care provider, unless in a case of emergency or with explicit consent from your doctor. I must also inform other providers that I am already taking pain medication prescribed by this office. I will keep this office informed of all medications I may receive from other physicians.
9. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being prescribed controlled substances. Violation will result in the termination of my care.
10. I understand that changing the date, quantity or strength of medication or altering a prescription in any way are against the law. Forging prescriptions or physician's signature are also against the law. Our office must cooperate fully with law enforcement agencies regarding infractions involving prescription medications.

11. I agree to submit random urine, blood, or saliva samples for toxicology testing. These tests, if requested, are to determine my compliance with my medication regimen and this agreement. Tests may include screens for illegal substances.
    - I understand that the laboratory responsible for urine processing and analysis is completely independent from Painlogics, and that there will not be any bias toward the testing process.
12. I understand medication renewals are contingent upon keeping scheduled appointments. Requests for medication refills may be denied due to frequent rescheduling or missed appointments. Medications will only be bridged until the next available appointment, during emergency circumstances.
    - Written prescriptions must be picked up at the office and cannot be mailed or delivered.
    - Refills will not be handled after hours, at night, on weekends or holidays.
    - If I run out early, lose or misplace my prescription, or if someone else has taken my medication, I understand that prescriptions cannot be replaced. I am responsible for keeping track of the amount of medications remaining. Prescriptions and bottle of medications must be safeguarded from loss and out of reach of children.

Signature _____ Date _____

Print Name _____