Associates in Women's Health of the Mahoning Valley, Inc.

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PAIN MEDICATION AGREEMENT

An Agreement in the event you are ever prescribed pain medication in this office

READ; INITIAL ON BLANK SPACES to indicate you have read and understand; **SIGN** at the end.
If you have any questions ask the employees for clarification.

As a patient of Dr. Hill's, I understand that it is in my best interest to be treated by one physician so that I have consistency in my medical care. This includes PAIN MEDICATION. I understand that the goal of treatment is to reduce pain and increase my ability to self-manage pain. Therefore before any pain medication can be prescribed or prescriptions written I must have an agreement on file and signed by myself. I understand that Dr. Hill alone will prescribe pain medication for me _____.

As a patient of Dr. Hill's, I understand that is my responsibility to keep track of the medication taken for pain_____.

I understand that at no time will replacement prescriptions be provided for lost or stolen prescription/medication _____.

I understand that my pain medication prescriptions **WILL NOT be filled early**. I understand that Dr. Hill **WILL NOT call in** new or refill prescriptions _____.

I understand that I must be seen by Dr. Hill to have my pain medication prescriptions refilled. I understand that I should make my appointment for refills prior to leaving the office. It is my responsibility to make sure I have an appointment before my prescriptions run out or expire. I understand that I am required to keep scheduled appointment with physicians, therapists, and other prescribed treatments for my pain management to which Dr. Hill may refer me. Repeated absences/missed appointments may result in being discharged from Dr. Hill's care. I will then need to find another physician to care for my medical needs_____.

I understand that Dr. Hill may require a urine drug screen at any time_____.

If at any time I refuse to or if I am unable to leave a sample for any reason, I understand that no narcotics will be prescribed. If illicit drugs or narcotics medications not prescribed by Dr. Hill are found in my drug screen, I understand that Dr. Hill will no longer prescribe narcotic medications for my pain and I may be discharged as a patient from this office. I understand there will be no second chances _____.

I agree and understand that **ONLY DR. HILL** will prescribe my pain medication. I will not obtain medication for pain from any other physician or other source. If it is found that I am getting or taking medication from another physician I will immediately be discharged as a patient in this office _____.

I understand that at any time I may be called to the office for a pill count and agree to come at the specified time with all my pain medications to verify that I am taking my prescriptions as prescribed _____.

I understand that I am not to operate motor vehicles or machinery while taking narcotic medications _____.

I understand that narcotics are addicting and I will assume full responsibility for my addiction I may experience _____.

**I agree to use only one pharmacy for my prescriptions. If for any reason I need to use a different pharmacy, I will inform Dr. Hill's office of the reason and provide the name and number of the pharmacy I am switching to _____.

By signing below, I agree to and understand the policies above. I agree to and understand my responsibilities pertaining to treatment provided to me in regard to pain medication. I understand that should I break any of these policies, it will result in immediate discontinuation of my narcotic pain medication prescribed by Dr. Hill.

_____Relationship_____Date_____
SIGNATURE of patient or Parent/Guardian of Minor Child

_____Relationship_____Date_____
SIGNATURE of WITNESS

**PHARMACY_____NUMBER_____