

McLaren Medical Group  
**PAIN MANAGEMENT AGREEMENT**

**The purpose of this Agreement is to prevent any misunderstandings about certain medicines that you will be taking for pain management. This is to assist both you and your doctor in complying with the law regarding pain medicines.**

**TERMS OF THE AGREEMENT:**

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my doctor will stop prescribing pain medicines.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on me daily, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., and agree that I may be tested for use of these substances at any time.

I will not share, sell or trade my medicines with anyone.

I will not attempt to obtain any controlled substances, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines, from any other doctor without coordination of care between doctors.

I will safeguard my medicine from loss or theft. I understand my doctor may not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my pain medicine, I understand my doctor will discuss this with me and may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of pain medicines. I agree to these additional measures, which I understand include limitations on my supply of pain medicines.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours because an evaluation of my circumstance or condition must be made. No refills will be available during evenings or on weekends.

I agree to use \_\_\_\_\_ Pharmacy, located at \_\_\_\_\_, for filling prescriptions for all of my pain medicines.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medicine for a period of time.

I will bring all unused pain medicine to every office visit.

**I understand that any provisions not followed in this Agreement could be grounds for discharge from care.**

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this Agreement has been given to me.

This Agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Patient: \_\_\_\_\_ Physician: \_\_\_\_\_

Witness: \_\_\_\_\_

PATIENT  
NAME:

DATE OF  
BIRTH: