**PAIN MANAGEMENT AGREEMENT**
**Rehabilitation Physicians of Georgia, P.C. (RPG)**

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and your doctor to comply with the law regarding prescription drugs.

I, _____, agree to use _____ Pharmacy, located

at_____, telephone number _____, for filling all of my prescriptions for pain medication.

- I will communicate openly and completely with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.
- I will not use any illegal controlled substances, including, but not limited to, marijuana and cocaine; nor will I abuse alcohol while being treated. I understand and agree that I will be denied service by RPG if in their clinical judgment I am impaired by any medication and/or alcohol. And that I may be required to seek alternative transportation in the event of such impairment.
- I will not share, sell or trade my medications with anyone.
- I will not obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other doctor or clinic without RPG's knowledge and consent.
- I will safeguard my pain medication from loss or theft. Lost or stolen medication will not be replaced.
- I understand and agree that refills of my prescriptions for pain medication will be made only at the time of an office visit during regular office hours. I will not miss my regularly scheduled appointments.
- I understand that aggressive behavior towards office staff or any RPG provider will not be tolerated.
- I agree to submit to a blood or urine test, if requested by my doctor, to determine my compliance with my program of pain control medication and I understand that I may have to pay for this test at my own expense.
- I agree that I will use my medication at a rate no greater or any less than the prescribed rate, and that use of my medication at a greater rate will result in my being without medication until my next prescription is due.
- I will not use my medication for any other purpose than that which is prescribed by my doctor or to control pain other than which I am in treatment for.
- I will not inject or inhale opioids intended for oral use.
- I will not alter in any manner a prescription written by my doctor.
- I will follow all applicable laws as they relate to my use of controlled medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Georgia's State Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations subject to applicable law.

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

I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this Agreement. **I understand that if I break any portion of this Agreement, my doctor will stop prescribing these pain control medications and my actions could lead to the permanent termination of the relationship with my doctor and RPG.**

This Agreement is entered into on this____ day of _____, 20___.

Patient's Signature: _____

Patient's Printed Name: _____

Physician's Signature: _____

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