MEDICATION MANAGEMENT AGREEMENT

This Agreement between_____(Patient) and Midwest Spine Interventionalist LLC (Doctor), is for the purpose of establishing an agreement between Doctor and patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the patient. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a Doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

___I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

___I realize that all the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

___I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform the activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

___I will not drink alcoholic beverages or use any illegal controlled substances, including marijuana, cocaine, etc. while taking the medication prescribed by the Doctor.

___I will not share, sell, or trade my medication. I understand that it is against the law to do so.

___I will not obtain any medication from another health care provider without telling them that I am taking pain medication prescribed by the Doctor. If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure that this is no duplication. **I will discontinue all previously used pain medications unless told to continue them.**

___I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

___I agree to use the same Pharmacy,_____, phone number_____ for all my pain medications. If I change my pharmacy for any reason, I agree to notify the Doctor at the time I receive my prescription, and advise my new pharmacy of my prior pharmacy's address and phone number.

___I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of pain medication and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this Agreement to my pharmacy.

___I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with this agreement and my regimen of pain control medication.

___I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will **result in my being without medication** for a period of time, **and could result in severe withdrawal symptoms or even death.**

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This agreement is entered into this_____day of_____2015.

_____ Patient

_____ Doctor

I acknowledge receiving a copy of this Agreement on the date stated above.

_____ Witness

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