Carolina Sports Medicine and Orthopaedic Specialists, P.A.
Pain Medication Agreement

I, _____, have agreed to use medications for the treatment of short-term pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day.

I understand and agree to the following guidelines for continuing pain treatment under the care of Carolina Sports Medicine:

- I will take medications at the dose and frequency prescribed. Early refills will not be allowed.
- I will **not** increase or change how I take my medications without the approval of this healthcare provider.
- I will allow ample time for my refill request to be processed.
- I will arrange for refills at the prescribed interval ONLY during regular office hours of ***Monday through Friday from 9:00 am through 3:00 pm***. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
- I will obtain all refills for these medications at _____ pharmacy, phone # _____, with full consent for my provider and pharmacist to exchange information in writing or verbally.
- I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking.
- I will inform my other healthcare providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will **not** be replaced.
- I will keep my medications only for my own use and will not share them with others. I will keep all medications away from children.
- I will not use illegal or street drugs or another person's prescription.
- I will not operate motor vehicles or machinery while taking this medication.
- I will keep all my scheduled appointments. If I need to reschedule my appointment, I will do so a minimum of 24 hours in advance. If I miss an appointment, no refills will be given.

I understand that this provider may stop prescribing the medications if:

- I do not follow the above guidelines.
- I do not show any improvement in pain or my activity level has not improved.
- I develop rapid tolerance or loss of improvement from the treatment.
- I develop significant side effects from the medication.
- My behavior is inconsistent with the responsibilities outlined above, ***which may also result in being prevented from receiving further care from this office.***

I have discussed the risks, benefit and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

Signature: _____ Date: _____

Witness: _____ Date: _____