WOOSTER PAIN AND ANESTHESIA CENTER, LLC

Maher Jeffrey Zackary, MD, MB, BCh

and

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WE TREAT YOU LIKE FAMILY

3373 Commerce Parkway, Suite 3

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Phone: (330) 439-4656 Fax: (888) 833-4132, (330) 601-0081

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PAIN MANAGEMENT AGREEMENT FOR CONTROLLED SUBSTANCES

The purpose of the Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management, while under our care. This is to help both you and your doctor to comply with the law regarding **controlled pharmaceuticals**. By signing this agreement, you indicate your intention to comply with the following:

- I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship, and that my doctor undertakes my treatment based on this Agreement.
- I understand that if I break this Agreement, my doctor will stop prescribing my pain control medications. In this case, my doctor may, as necessary, taper me off my medicines over several days in order to avoid withdrawal symptoms. In addition, a drug-dependence treatment program may be recommended.
- **I agree to use my medicine at a rate no greater than the prescribed rate. I understand that if I use my medicines at a greater rate than prescribed, I will be out of medicine for a period of time, which may result in withdrawal symptoms. I understand that if I run out of medicines, the doctor may not refill them early.**
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is working to relieve my pain symptoms.
- I agree to participate fully in all aspects of my care, including all recommended treatments.
- **I will not use any illegal controlled substances, including marijuana, cocaine, methamphetamine's, etc. Although alcohol is not illegal, it will interact with controlled substances and increase the risk of sedation and overdose and its use is discouraged.**
- I will not share, sell or trade my medications with anyone or use medications not prescribed for me.
- **I will not attempt to obtain any controlled medicines, including pain medicines, from any other doctor. I understand that the treatment of pain includes any and all pain that I might experience, and is not limited to just the pain that I have been referred for treatment.**
- I will safeguard my medications from loss or theft, and I understand that lost or stolen medications are **not replaced**.

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- I understand that medication refills are made only at regularly scheduled office visits or during regular office hours. I understand that no refills will be made during the evenings, or on weekends.
- **I agree to submit to a urine test, if requested by my doctor, to determine my compliance with my program of pain control medicine. Fees may apply. Ask the receptionist for the complete policy.**
- I understand that failure to show for a scheduled appointment, or no show, including cancellation within 24 hours of a scheduled appointment places an additional burden on the staff in coordinating patients to be seen. In addition, I understand that these appointment slots are not available to be filled by other patients in need of services. I understand, therefore, that **three no-shows or cancellations within 24 hours of scheduled appointments within a 12-month period is unacceptable behavior that will result in discharge from the practice.**
- **I agree to come in to the office, or other specified location, when requested for a pill count. I understand that I must comply with the requested pill count by the end of the business day. If I fail to comply with this request, I understand that I may be discharged from the practice.**
- I agree to always use ______________________________ pharmacy,

  located at ____,for filling my prescriptions for pain medications.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicines. I also 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.
- **(FEMALES ONLY)** I certify that I am **not pregnant** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them-I am aware, that should I carry a baby to delivery while taking these medicines; the baby will become physically dependent upon opioids. I am aware that use of opioids is generally not associated with a risk of birth defects. However, birth defects can occur-whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid

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CONTINUED

- **(MALES ONLY)** I am **aware** that chronic opioid use has been associated with **low testosterone levels** in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I **understand** that my doctor may check *my* blood to see if my testosterone level is normal.
- **I agree to follow these guidelines, as 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.**

Patient signature: ______________________________ Date: ________________

Provider signature: ______________________________ Date: ________________

Witnessed by: ______________________________ Date: ________________