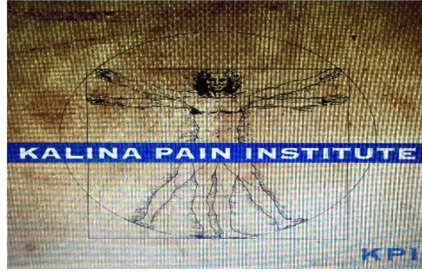

OPIOID PAIN MEDICATION AGREEMENT
Kalina Pain Institute
Dr. Jared A. Kalina

I understand that **Dr. Jared A. Kalina** is prescribing opioid medication to assist me in managing chronic pain. The risks, side effects, and benefits have been explained to me, and I agree to the following conditions of opioid treatment.
1. The medication must be *safe and effective* and help me to *function better*. The goal is to use the lowest dose that is both safe and effective. If my activity level or general function gets worse, the medication will be changed or discontinued by my clinician.
2. I will participate in *other treatments* that my clinician recommends and will be ready to taper or discontinue the opioid medication as other effective treatments become available.
3. I will take my medications exactly as *prescribed* and will not change the medication dosage or schedule without my clinician's approval.
4. I will keep *regular appointments* and will call at least 24 hours in advance if I have to reschedule.
5. *One clinician.* All opioid and other controlled drugs for pain must be prescribed by the clinician who is named above. I will not obtain medications from other clinicians or pharmacies unless I am hospitalized. I will tell any hospital or emergency room clinicians that I receive pain medications from my provider. In the event of an emergency, if I am given a prescription for pain medication, I will notify my primary clinician as soon as I am able.
6. *One pharmacy.* I will designate *one pharmacy* where all my prescriptions will be filled. I am responsible for prescriptions being filled on time. To avoid running out of my medications, I will contact my provider's office at least 3 business days in advance for refills. I understand that prescriptions generally will not be sent by mail or faxed.
7. I understand that lost or stolen prescriptions *will not be replaced*, and I will not request early refills.
8. I agree to abstain from excessive alcohol use and all illegal and recreational drug use and will provide urine or blood specimens at the clinician's request to monitor my compliance.
9. I understand that my health information may be exchanged with other health care practitioners and pharmacists to assist in my treatment, including pain management and utilization of pain medications.
10. I understand that clinic staff (nurses, receptionists, lab staff, etc.) is very important in my success with this treatment plan. I will treat them respectfully and abide by their decisions regarding my care and the enforcement of this agreement.
11. If I am unable to follow the conditions of this agreement, I understand it may not be safe for me to continue the medication.
12. Other: ____

Patient Signature: ___________________ Patient Name Printed: __________________

Clinician Signature: _________________________

Date: ________________ Time: ____________