COLUMBIA CLINIC
Pain & Ortho-Spine Institute

Usama A. Gabr, MD, FAAPMR, CIME
Physiatry & Rehabilitation Associates

Pain Management Agreement

_____ (patient receiving chronic pain medications), have agreed to use medications as part of my treatment for chronic pain. Understand that these medications may not eliminate my pain buy may reduce it and improve what I am able to do each day.

I understand that the Pain Management Clinic will address my chronic pain and will n to address other chronic medical conditions unless deemed appropriate by your physician.

I understand the following guidelines for continuing chronic pain treatment under the care of (physician prescribing chronic pain medications) _____.

1. I understand that I have the following responsibilities:
   a. I will take medications at the dose and frequency prescribed.
   b. I will not increase or change how I take medications without the approval of the prescribing physician.
   c. I will not ask for refills earlier than agreed. I will arrange for refills at the prescribed interval **ONLY during regular office hours**. This includes after-hours, on holidays.
   d. I will obtain all pain medications only at the one pharmacy.
   e. Pharmacy: _____ Phone #: _____
   f. I authorize my physician to provide a copy of this contract to my pharmacy.
   g. I will not request any pain medication of controlled substances from other providers and will inform this physician of all other medications I am taking. I understand that other physicians should not change doses of my pain medications and I will notify the Pain Management Clinic of any changes to my pain medications made by other providers. This applies to the hospital visits as well unless there is a life threatening illness and that will be based on the judgments of the treating physician at the time who will be informed about my medications and agreement.

   I agree to use only the following providers. I will notify my physician if any changes in my healthcare and/or changes in my provider.

   Provider: _____ Clinic: _____ Phone #: _____
   Provider: _____ Clinic: _____ Phone #: _____
   Provider: _____ Clinic: _____ Phone #: _____

2. I will inform my other healthcare providers that I am taking these pain medications and other existence of this agreement. In the event of an emergency, I will provide this same information to emergency providers.
3. I will allow my physician to discuss all diagnostic and treatment details with pharmacists, physician, or other healthcare providers who provide my healthcare for purposes of maintaining accountability.
4. I will inform my physician of any medications of medical conditions.
5. I will protect my prescriptions and medications. **I understand that lost or misplaced prescriptions will not be replaced**.
6. I will keep medications only for my use and will not share them with others. I will keep all medications away from children.
7. I will bring all medications (including those prescribed by other healthcare providers) in the original prescription bottle to all appointments.
8. **I will participate in any medical treatment, psychological, or physiatric assessment recommended by my physician**.
9. I will actively participate in any program designed to improve functions, including social, physical, psychological and daily activities.
10. I will not use **street drugs** (including marijuana, cocaine, etc.) or another person's prescriptions. I will inform my physician of alcohol addictions and/or street use, past, present, as well as any history of alcoholism/addiction.
11. I will actively participate in any treatment program for drugs and alcohol addictions if my physician asks me to enter such a program. Programs may include:
    a. Step program and securing a sponsor
    b. Individual counseling
    c. Inpatient or outpatient treatment
    d. OTHER: _____
    e. If I am in a treatment program, I will provide documents from the treatment program to validate my progress and treatment.