



3280 Urbana Pike, Ste 207
Ijamsville, MD 21754
PH: 301-874-3431

Pain Management Treatment Agreement*

I understand and voluntarily agree that:

I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

I will participate in all other types of treatment that I am asked to participate in.

I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

I will sign a release form to let the doctor speak to all other doctors or providers that I see.

I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

I will use only one pharmacy to get all on my medicines: _____
Pharmacy name/phone#

I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient signature _____ Patient name printed _____ Date _____