

ORTHOPAEDIC & SPORTS MEDICINE AT CYPRESS, LLC

CONTROLLED SUBSTANCE MEDICATION FOR PAIN MANAGEMENT TREATMENT AGREEMENT

I understand that, _____, M.D./P.A. is prescribing a controlled substance medication for pain management. This treatment agreement is a platform for communication allowing us to work together in good faith, and for you to understand the importance of this medication in allowing you to function better. We expect to be partners in creating the best treatment plan for your pain management. If you cannot agree with the following points, it will result in discontinuing the controlled substance.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my Physician, Physician Assistant and/or Nurse Practitioner.
2. I will keep regularly scheduled appointments with my Physician, Physician Assistant and/or Nurse Practitioner. There may be times when your medication will need a refill between visits. In this instance, please call our staff at least 1 to 2 days before your medication runs out. Refill requests will only be taken on Monday – Thursday from 8 am to 5 p.m. Your Physician, Physician Assistant and/or Nurse Practitioner on call will not refill any pain meds after hours or over the weekend. This is not an emergency and will not be treated as such.
3. The controlled substance pain medication prescribed is being given in order to control pain and allow you to function better. If there are any changes to my activity level or my physical condition, the treatment may be changed or discontinued.
4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves.
5. I agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.
6. We expect you not to accept or seek controlled substance medications from other physicians or healthcare providers outside of our practice.
7. If you have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing physician, including any pain medication for your orthopedic condition.
8. I agree that Orthopaedic & Sports Medicine at Cypress, LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.
9. It is important to use one pharmacy for all prescriptions in order to provide consistency.

Pharmacy: _____ Phone: _____

10. I understand that lost, stolen, or misplaced prescriptions will not be replaced. All patients are expected to act responsibly with their medication. This medication is prescribed for you and only your needs for pain control. To allow others to use your pain medication is illegal and will not be tolerated by our physician or our practice.
11. Using illegal and recreational drugs in dangerous with prescription medications.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____



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