Pain Medication Agreement

Carefully review each statement below and initial after reviewing.

I understand and voluntarily agree to the following statements:

I will store my medication where it is safe from theft and out of reach of children. Stolen or lost medication will NOT be replaced until my next refill is due 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 my doctor _____

I will not call at night or on weekends to request refills. I understand that my prescription will only be filled at the regularly scheduled times with approval of my primary doctor and will not be filled early under any circumstances. _____

I will make sure I schedule and keep routine appointments with my Primary Care Physician. If I am having trouble making an appointment I will contact the Patient Relations Department at 909-883-8611, Ext 2503. _____

I will treat the physician and office staff respectfully at all times. I understand that if my behavior is threatening, disrespectful or disruptive there is a possibility that I will be dismissed from the medical group. _____

I understand that if I sell or share my medication with others my treatment will be stopped. _____

I will sign a release form to let my doctor speak to any other medical professional involved in my care _____

I will inform my doctor of all other medications I am taking and will inform my doctor within 72 hours if I receive any prescriptions for new medications from another doctor _____

I will use only one pharmacy for all of my medications. The name and phone number of that pharmacy is

_____ _____

Pharmacy Name Phone Number

I will not get any opioid / narcotic pain medicines or other medicines that can be addictive without telling my doctor BEFORE I fill those prescriptions. The only exception to this would be if I needed pain medicine for an emergency at night or on weekends. I will notify my doctor of the emergency on the next business day _____

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 random drug testing within 24 hours of being called and understand that drug screening may be required at least every 90 days to make sure I am taking only the medicines prescribed to me _____

I understand that I am responsible to make sure the office has current contact information in order to reach me, and that any missed drug tests will be considered positive for other drugs _____

I will keep up to date with all my financial responsibilities with the office and will tell the doctor immediately if I lose my insurance and can no longer pay for treatment _____

I understand that San Bernardino Medical Group will check the electronic prescription drug database to see if I am being prescribed other medications by other physician's _____

I understand that I may lose my right to treatment with San Bernardino Medical Group if I break any part of this agreement.

_____ _____ _____

Patient name (please print) Date of birth Primary Care Physician

_____ _____

Patient signature Date contract signed