Richard M. Foltz, MD

NORTH BROWARD NEUROSPINAL SURGERY

PAIN TREATMENT WITH OPIOD MEDICATIONS: PATIENT AGREEMENT

understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical lependency. I understand that failure to follow any of these agreed statements might result in the doctor not providing ongoing care or me. **I agree to the following statements:**

I will not accept any narcotic prescriptions from another doctor.
I will be responsible for making sure that I do not run out of medications on weekends and holidays, because abrupt liscontinuation of these medications can cause severe withdrawal syndrome.
I understand that I must keep my medications in a safe place. I understand that the doctor will not supply additional refills for the prescriptions of medications that I may lose.
I will not give my prescriptions to anyone else.
I will only use one pharmacy.
I will keep my scheduled appointments with the doctor unless I give notice of cancellation 24 hours in advance.
I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by the doctor.
My treatment plan may change based on outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued.
I agree to give a blood, urine, or saliva sample, if asked, to test for drug use.

understand that the doctor believes in the following "Pain Patients Bill of Rights." **As a patient, I have the right to:**

Have your pain prevented or controlled adequately.
Have your pain and medication history taken.
Have your pain questions answered.
Know what medication, treatment or anesthesia will be given
Know the risks, benefits, and side effects of treatment
Know what alternative pain treatments may be available.
-Ask for changes in treatments if your pain persists.
-Receive compassionate and sympathetic care.
-Receive pain medication on a timely basis.
-Refuse treatment without prejudice from your physician.
-Include your family in decision making.

SAMPLE TERMINATION CLAUSES

The doctor may terminate this agreement at any time if he has cause to believe that I am not complying with the terms of this greement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the erms of this agreement.
I understand that I may terminate this agreement at any time.
If the agreement is terminated, I will not be a patient of the doctor and would strongly consider treatment for chemical dependency f clinically indicated.

_____ _____/_____/_____
Patient's Signature Date

_____
Patient's Printed Name

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