MEDICATION MANAGEMENT AGREEMENT

This Agreement between Dr. Tomaszek and you is for the purpose of establishing clearly the conditions for receiving pain controlling medication prescriptions as provided by the doctor for you the "Patient". For the purpose of this agreement, "Doctor" will refer to any physician of Doctor Tomaszek providing medications or treatment for your condition. The Doctor and Patient agree that adherence to this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by Dr. Tomaszek.

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of treatment.

- I realize that all of the medications have potential side effects and I will have any recommended laboratory studies requested to keep the regimen as safe as possible. I agree that I will submit to an immediate blood or urine test, if requested by my Doctor, to determine my compliance with my regimen of pain control medication.

- I realize that it is my responsibility to keep others and I free from harm. This includes but is not limited to the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity while under the influence of my medication. I assume all responsibility for any harm to others or myself that may result from my undertaking any activity that I choose to perform while impaired.

- I will not at any time use illegal controlled substances, including marijuana, cocaine, etc. Use of such substances may result in immediate termination of care by the Doctor. I further understand that the consumption of alcohol while using pain medication is strictly prohibited.

- I will not share, sell or trade my medication for money, goods or services. Doing so may result in immediate termination of care by the Doctor.

- I will **not attempt to get and will not accept pain medication** from any other health care provider or any other person without first obtaining consent from Dr. Tomaszek. I will notify other health care of all medications provided by Dr. Tomaszek. Failure to do so may result in immediate termination of care by Dr. Tomaszek.

- **I will safeguard my medications from loss or theft and agree that the consequences of my failure to do so, I will be without my prescribed medications for a period of time**.

- I agree to use one pharmacy only for **all** my prescribed pain medications. If I change pharmacies for any reason, I agree to notify the Doctor immediately and advise my new pharmacy of my prior pharmacy's address and telephone number.

- I agree to waive any applicable privilege, right of privacy or confidentiality with respect to the prescribing of my pain medication. I authorize Dr. Tomaszek and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Board of Pharmacy, for the purpose of any investigation into possible misuse, sale or other diversion of my pain medication. I authorize Dr. Tomaszek to provide a copy of this Agreement to my pharmacy or any of my other treating physicians or healthcare providers.

- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate without prior consent of my Doctor **will result in my being without medication for a period of time.**

- My care will be periodically reviewed and if there is no evidence that I am improving or that progress is being made to improve my function or quality of life, the regimen of medications may be tapered terminated or I may be referred to an appropriate caregiver for detoxification.

The Doctor and Patient agree that the above is essential to the Doctor's ability to treat the Patient's pain effectively and that **failure of the patient to abide by the terms of this agreement may result in the termination of the Doctor/Patient relationship.** This agreement is to remain in effect until the Doctor/Patient relationship is no longer in existence.

This agreement is entered into on this__________day of________________, 20___

I have had the opportunity to ask questions regarding this document and understand all implications of the above agreement.

_________________________________ ____________________________________

Patient signature witness signature