Trinity Family Medical Center, P.A.
Health "Care" for the Body, Mind and Spirit

Stephen E. Young, D.O.

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Medication Contract

I,_____, have agreed to use the following medications as part of my treatment for chronic pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day.

MEDICATION	DOSE	DIRECTIONS	QUANTITY PER MONTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand the following guidelines for continuing pain treatment under the care of

_____ Dr. Stephen E. Young D.O. _____

1. I understand that I have the following responsibilities:

- I will take medications at the dose and frequency prescribed.
- I will not increase or change how I take my medications without the approval of this health care provider.
- I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agrees, after-hours, on holidays or on weekends.
- I will obtain all refills for these medications only at _____ pharmacy (phone number:____ _____), with full consent for my provider and pharmacist to exchange information in writing or verbally.
- I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking.
- I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In event of an emergency, I will provide this same information to emergency department providers.

- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
- I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.
- I actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.

2. I will not use illegal or street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:

- 12-step program and securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment
- Other:_____

If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. I will keep all my scheduled appointments. If I need to cancel my appointments, I will do so a minimum of 24 hours before it is scheduled.

5. I understand that this provider may stop prescribing the medications listed if:

- I do not show any improvement in pain or my activity has not improved.
- I develop rapid tolerance or loss of improvement from the treatment.
- I develop significant side effects from the medication.
- My behavior is inconsistent with the responsibilities outlined above, ***which may also result in being prevented from receiving further care from this clinic.***

Signed:_____ Date:_____

Provider:_____ Date:_____

Stephen E. Young, D.O.