James E. Dowd, MD, PC
Board Certified Adult and Pediatric Rheumatologist
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Pain Medication Agreement

Patient Name (Print): _____ DOB:_____

All patients are required to sign this medication agreement regardless of their current need for prescription pain medication. Failing to follow these rules will result in your dismissal from our practice.

I agree to and understand the following as part of my pain treatment plan:

- By law, physicians are required to gather a comprehensive medical and medication history before prescribing narcotics. Therefore, **NO** pain prescriptions will be prescribed at the first visit.
- If receiving a narcotic medication from James E. Dowd, MD, I will receive my narcotic medication **ONLY** from James E. Dowd, MD.
- Dr. Dowd will provide education, including the risks associated with taking Opioid medications. This education is mandatory, must occur in person and must be signed by the physician and patient, before opioid containing medications can be prescribed.
- A report from the State of Michigan will be pulled before any pain medication will be prescribed. The report will show all controlled substances that have been prescribed and filled, along with the pharmacy information and method of payment (cash or insurance). Scripts cannot be filled until this report has been pulled and reviewed. It may take 72 hours for this process to be completed.
- I agree to take my medications **only as prescribed**.
- I agree to fill my prescription at **one pharmacy**. If an exception is made because of supplies or cost, I will advise the practice immediately.
- I agree to keep my medications safe at all times. **These drugs may be hazardous or deadly to people**. New prescriptions will not be written for lost or stolen medications. No exceptions!
- I agree that I need to be monitored while on narcotic medication and I will **keep all scheduled appointments**.
- I agree to **abstain from alcohol or illegal drug** use while taking narcotic medication.
- I understand that **refills require regular visits and I must keep all scheduled appointments**. There are no early, weekend, holiday or evening refills. Refills requested on Fridays, will not be filled until the following Monday.
- I agree **not to drive, operate machinery or serve in the public sector.**
- I agree to **never share, sell, or exchange medications**.
- I agree to maintain a patient relationship with a **family doctor in Michigan**.
- I understand my provider may choose to taper my pain medications at any time, if he deems necessary.
- I will **inform all other providers** including dentists, surgeons, emergency room, urgent care and primary care, of narcotic prescriptions provided to me.

I have read the entire agreement and have had all my questions and concerns answered and addressed. By signing below, I agree to follow the guidelines set forth by the office of James E. Dowd, MD, PC.

_____ _____

Patient Signature Date