Lafayette Pain Care
TREATMENT AGREEMENT

Disclaimer: Dr. Shazia Siddiqui is a pain specialist treating acute and chronic pain. The purpose of this agreement is to prevent misunderstandings about controlled medication(s). This is to help you and the physician to comply with state and federal laws/regulations regarding controlled pain medication(s).

I, _____ understand that this agreement is essential to the trust and confidence necessary in a doctor/patient controlled pain medication(s).

____ I will communicate fully with the physician about the character and intensity of my pain, the effect of the pain during daily activities, and how effective the prescribed controlled pain medication(s) is in treating my condition.

____ I understand and agree that my prescribed controlled pain medication(s) will not be refilled earlier than scheduled and I agree not to ask this of my physician. In the event that my refill date falls over a weekend, I will be able to pick up my prescription the Friday before.

____ I will not sell, share, or trade my prescribed controlled pain medication(s) with anyone, regardless of the situation. If I require a change in controlled medication(s), I am required to bring any/all of my previously prescribed pain controlled medication(s) back to the physician's office for a count prior to receiving a new prescription. If I fail to comply, I may be discharged from my physician's practice within 30 days of his notification.

____ I agree to use only Dr. Siddiqui to obtain any/all controlled pain medication(s). If I choose to use another physician and I have established a doctor/patient relationship prior, then I may continue to do so as long as I communicate this with Dr. Siddiqui. If I do not do so, then I may be subject to immediate dismissal by Dr. Siddiqui for pain control medication(s).

____ I will safeguard my controlled pain medication(s) from LOSS or THEFT. I understand that lost, dropped, or stolen controlled pain medication(s) may not be refilled until the due date, and I agree not to ask this of my physician.

____ I understand that a ONE TIME exception may be made in the event that I provide a police report documenting the LOSS OR THEFT of my controlled pain medication(s).

____ I agree not to use any illegal controlled substances. I agree to submit to a drug test at the physician's request.

____ I agree to come in on the day my physician calls for a controlled pain medication(s) count so all of your controlled pain medication(s) can be counted and documented in your chart by two licensed clinic Personnel; the medication MUST be in the original bottle. I understand that I must provide my physician with a valid phone number/address.

____ I agree to come to the office for refills of all of my controlled pain medication(s). In the event of an EMERGENCY, I may receive a ONE TIME prescription call in, depending on the level of controlled pain medication(s).

____ I authorize Dr. Siddiqui and my pharmacy to fully cooperate with any city, state, or federal law enforcement agency. This includes the Indiana's Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my prescribed controlled pain medication(s).

____ I authorize the Lafayette Pain Care to provide a copy of this agreement to my pharmacy.

_____ _____

Pharmacy **Phone Number**

Lafayette Pain Care

TREATMENT AGREEMENT

____ I authorize the Lafayette Pain Care, Dr. Siddiqui, and/or one of the appointed nurses to investigate my history of controlled pain medication(s) use.

____ I agree to bring all unused/left over controlled pain medication(s) to every office visit. The medication(s) MUST be in the original bottle.

____ I agree to follow these guidelines that have been fully explained to me. I have been given a chance to have all of my questions/concerns answered and addressed adequately. I understand that a copy of this agreement is available to me at any time, upon my request.

____ I understand that if I fail to comply with any on of the terms of this agreement, Dr. Siddiqui may decide to change my treatment plan to one that does not include prescribing controlled pain medications. I also understand that with this failure I may be discharged from his practice after a 30 days notification.

This agreement is entered into on this date: _____.

_____	**_____**
Printed Patient Name	**Patient Signature**
_____	**_____**
Physician Signature	**Witness**