



Pain Management • Non-operative Spine Care • EMG/NCS • Sports Medicine

PAIN MANAGEMENT CONTRACT AND PROGRAM RULES

I have agreed to use controlled medications as a part of my treatment for pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal government. Because my physician is prescribing such medication(s) to help my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of my contract, and at the sole discretion of my physician, may result in the termination of our physician-patient relationship.

1. I will receive controlled medications only from Michael G. Ellman, M.D. If I receive controlled medications prescribed by other physicians, my treatment will be stopped.
2. I will use the medication(s) only as prescribed by Michael G. Ellman, M.D.
3. I understand that combining medications with controlled medications may cause drowsiness, intoxication or death. Some of these medications are tranquilizers (downers), stimulants (uppers), diet pills, sleeping pills, alcohol or other street drugs.
4. I understand that if I use more medications than prescribed, sell or let other people use them, collect them or obtain/use other medications not authorized by my physician, he/she may refuse to continue prescribing these medications. A referral to an Addiction Treatment Specialist may be made.
5. I will select one pharmacy to fill my prescriptions and inform my physician of any changes.
6. I understand that refills will be made on a scheduled basis as determined by my physician. Refills may also be obtained at the time of a scheduled appointment or by calling **the medication refill line at 972.682.3909 ext. 17**.
7. I will call for refills 2 – 3 days before running out of medication. I understand that refills **will not** be made after office hours, weekends or on holidays.
8. If my medication(s) is/are stolen, I will report this to the staff of Michael G. Ellman, M.D. ASAP but I do understand that my medication(s) will not be refilled until the date that the lost or stolen medication(s) would have run out.
9. I understand that I must see my physician regularly. This requires a scheduled visit. Refills will not be made if I do not keep this appointment. My response to treatment using these medications will be evaluated at each visit.
10. I understand that I may have to submit to blood or urine tests to check if I am following these rules.

Patient's signature

Date

Physician's signature

Date