Comprehensive Neurology, P.A.
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Pain Management Agreement

Patient Name:______________________________________ Birth Date:________________

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Dr. Carl Yacoub not providing ongoing care for me.

I agree to undergo pain management by Dr. Yacoub. My diagnosis is:

____

I agree to the following statements (***please initial each applicable line***):

___I will not accept any narcotic prescriptions from another doctor.

___I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome.

___I understand that I must keep my medications in a safe place.

___I understand that Dr. Yacoub will not supply additional refills for the prescriptions of medications that I may lose.

___If my medications are stolen, Dr. Yacoub will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.

___I will not give my prescriptions to anyone else.

___I will only use one pharmacy.

___I will keep my scheduled appointments with Dr. Yacoub unless I give notice of cancellation 24 hours in advance.

___I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by Dr. Yacoub.

___I will inform Dr. Yacoub of any changes in my health status, including initiation of treatment for substance (including alcohol) abuse.

My treatment plan may change based on outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued.

My treatment plan includes:
□Medications
□Physical Therapy/Exercise
□Relaxation Techniques
□Psychological counseling

I understand that Dr. Yacoub believes in the following "Pain Patients Bill of Rights."
You have the right to:

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits, and side effects of treatment.
- Know what alternative pain treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your physician.
- Include your family in decision-making.

___The doctor may terminate this agreement at any time if he has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.
___I understand that I may terminate this agreement at any time.

If the agreement is terminated, I will not be a patient of Dr. Yacoub and would strongly consider treatment for chemical dependency if clinically indicated.

________________________________ ______________
Patient Signature Date

________________________________ ______________
Physician Signature Date

________________________________ ______________
Witness Signature Date