RHEUMATOLOGY CENTER OF SAN DIEGO
Tania L. Rivera, M.D.

# PAIN MANAGEMENT AGREEMENT

**This agreement is important to help maintain the trust and confidence necessary in a Patient/Healthcare Provider Relationship. The Patient agrees to and accepts the following conditions in order to receive habit-forming/controlled medications:**

1). I understand that the goals of management include a reduction in the intensity of my symptoms and, whenever possible, an improvement in my quality of life, but **complete relief of pain/anxiety/etc. may not be an achievable goal** for many patients.

2) I understand that chronic use of habit-forming medication has the **potential to result in tolerance, dependence, abuse, and addiction.**

3) I understand that Dr Tania L Rivera **may elect to modify or discontinue a management plan** at any time if she determines that the currently prescribed regimen fails to demonstrate effectiveness after a reasonable trial.

4) I understand that the **use of alcohol and illegal controlled substances**, including but not limited to cocaine, ecstasy, heroin, methamphetamine and PCP **may increase the risk of complications** resulting in serious medical illness or death. **I will not use illegal controlled substances and agree to submit to a blood or urine test** if requested by Dr Tania L Rivera to assist in determining my compliance with this agreement.

5) I understand that **I may be discharged from management** with habit-forming medications if it can be reasonably determined that my **use of any substances, or my misuse of the prescribed regimen, has placed me or put others at increased risk** for medical or other complications.

6) **I will not share, sell, or trade my medication** for money, goods or services.

7) I agree that I will **take my medication at a rate not greater than as instructed** and that if used at a greater rate, I may be without medication for a period of time. I understand my **medication may not be replaced if lost or stolen**.

8) I agree to schedule and keep my **appointments for regularly prescribed medication** and understand that I **will not be given a prescription for habit-forming medication if I request such services on a walk-in basis, by telephone or fax.** To the extent possible, follow-up appointments should be made with the provider of record, unless that provider is unavailable because of unplanned absence, vacation, schedule conflict or transfer.

9) I understand that Dr Tania L Rivera is my physician of records. **I agree not to take any habit-forming medication prescribed by any other provider** without first discussing it with the above-named physician, except in an emergency which I agree to reveal to Dr Tania L Rivera prior to receiving any additional medication.

RHEUMATOLOGY CENTER OF SAN DIEGO
Tania L. Rivera, M.D.

10) **I agree to use only ONE pharmacy to fill all habit-forming medication prescriptions. I further agree to promptly notify my provider of any changes.**

I select _____
as my chosen pharmacy. Phone number _____

11) I understand my permission is not required for Dr Tania L Rivera **to verify that I am not going to other pharmacies or seeing other providers for habit-forming medication,** since this information is available to providers from the California Department of Justice, which monitors all controlled medication prescriptions filled, but I give my permission for my provider to use other means as well when needed to verify my compliance with this provision.

12) I understand that my **failure to abide by the terms of the Agreement may result in the withdrawal of all prescribed habit-forming medication** by Dr Tania L Rivera and termination of the existing physician/patient relationship for the management of my condition. Unacceptable actions, such as **prescription forgery or threatening/violent behavior, may result in being barred from all services at Rheumatology Center of San Diego PC.**

13).This agreement shall remain in effect unless it is amended or revoked in writing

Signed on _____

_____

Patient Signature

_____

Patient's name and DOB

Tel (858) 336-2810 • Fax (949) 798-7990
215 S Hickory St, Suite 114, Escondido, CA 92025 • 9850 Genesee Ave, Suite 560, La Jolla, CA 92037 •
320 Santa Fe Dr,Suite 212, Encinitas, CA 92024
Se habla Español • www.rheumSD.com