

John K. Hong, M.D.  
Interventional Pain Specialist  
Board Certified, ABA

Main: 630.226.1130  
Fax: 630-226-1134  
Web: gatewaypain.com

**MEDICATION MANAGEMENT AGREEMENT**

*The purpose of this agreement is to protect your access to medications, to protect our ability to prescribe to you, and to ensure your safety and maximum benefit from the medications.*

- I understand that opioid analgesics and adjuvant analgesic medications may be controlled substances, which are restricted legally as to prescription, use, and distribution.
- I understand that opioid analgesics may cause physical dependence, complications upon withdrawal, sedation, respiratory depression, and death.
- I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
- If I have developed an abuse or addiction problem with opioid analgesics, adjuvant analgesic medications, or both, I agree to be assessed and to comply with all recommended treatment.
- I understand that the staff at Gateway Spine and Pain Physicians may need to count my pills and/or test my urine randomly to make sure I am using my medications properly.
- I understand that if I am pregnant or become pregnant while taking any medications, I will notify my physician immediately.
- I will not operate motor vehicles, or serve, in any capacity, related to public safety if my medications impair my alertness, coordination, or judgment.
- I understand my medications will be continued only if the medications significantly improve my ability to function, the side effects are not interfering significantly with the benefits of the medication, and I demonstrate consistent and effective use of non-pharmacological techniques for self-management of chronic pain.
- I understand that it is the responsibility of the patient/guardian to give GSAPP 3 business days advance notice when new medications or medication refills will be needed; any requests for medications made with fewer than 3 business days' notice may not be granted.
- ⚙️ I understand that refills will not be granted after business hours or weekends and that there are no early refills or replacement of lost or stolen opioid analgesics and adjuvant analgesic medications for any reason whatsoever.
- I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists and other professionals who provide my health care for purposes of maintaining accountability.
- I will not allow anyone else to have, use, sell, or otherwise have access to these medications and that unauthorized use may lead to hazardous or lethal side effects.
- I understand that tampering with a written prescription is a felony and I will not change or tamper with the written prescription. I am aware that attempting to obtain controlled substance under false pretenses is illegal.
- ⚙️ I agree to take my medications strictly as ordered, unless I get specific instructions from my physician or nurse to alter my dosage schedule. I will not exceed the maximum prescribed dose.
- I understand that any medication is contingent on whether my physician believes that the medication usage benefits me.
- All controlled substances must come from a physician in this office and from one pharmacy only; any pain related medications from other physicians must be approved by this office before they are filled.
- I understand that if I do not abide by these regulations, I may be discharged from this practice.
- Follow-up appointments must be kept by physicians recommendation

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

**I affirm that I have full right and power to sign and be bound by this agreement and that I have read, understand, and accept all of the above terms.**

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

11132012MA