Collaborative Pain Management Agreement

Date: [Date]

Patient Name: [Patient's Name]

Patient ID: [Patient ID]

Provider Name: [Provider's Name]

Provider Contact Information: [Provider Contact Info]

Introduction

This agreement outlines the expectations and responsibilities of both the patient and the healthcare provider regarding pain management treatment.

Goals of Treatment

- To achieve optimal pain control.
- To enhance the quality of life.
- To improve daily functioning.

Patient Responsibilities

1. Follow the treatment plan agreed upon with the provider.
2. Communicate openly about pain levels and treatment effectiveness.
3. Inform the provider of any side effects from medications.
4. Attend scheduled appointments regularly.

Provider Responsibilities

1. Provide comprehensive assessments and treatment options.
2. Monitor the patient's response to treatment.
3. Adjust the treatment plan as necessary for optimal outcomes.
4. Educate the patient about their condition and treatment options.

Agreement Terms

By signing below, both parties agree to adhere to the terms set forth in this collaborative pain management agreement.

Patient Signature: ____________________ Date: _____________

Provider Signature: ____________________ Date: _____________