Chronic Pain Opioid Monitoring Contract

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Dear [Patient Name],

This letter serves as a contract between you and [Provider's Name/Practice Name] regarding your treatment plan that includes the prescription of opioid medications for chronic pain management. The following terms are agreed upon to ensure safe and effective treatment:

1. Medication Usage

You agree to take your opioid medications as prescribed, without alterations, and notify us immediately of any side effects or concerns.

2. Prescription Refills

Refills will only be provided during scheduled appointments. A minimum of [Insert Time Frame] will be required between appointments for refill eligibility.

3. Drug Testing

You consent to periodic drug testing to ensure compliance with this contract and verify that medications are taken as prescribed.

4. Sharing Prescriptions

You agree not to obtain prescription opioids from any other healthcare provider without prior written consent from [Provider's Name/Practice Name].

5. Policy on Misuse

Misuse of medications, including altering prescriptions or lost medications, may result in discontinuation of opioid therapy.

By signing below, you acknowledge that you have read and understood the terms outlined in this contract and agree to abide by them.

Signature: _____

Date: _____

Provider's Name: _____

Provider's Signature: _____

Thank you for your commitment to responsible pain management.

Sincerely,
[Provider's Name/Practice Name]