Opioid Therapy Accountability Agreement

Date: _____

Patient Name: _____

Patient Address: _____

Practitioner Name: _____

Practitioner Address: _____

1. Purpose

This agreement outlines the responsibilities and commitments of both the patient and the practitioner regarding the use of opioid therapy for pain management.

2. Understanding of Opioid Therapy

By signing this agreement, I understand that opioid medications carry risks including, but not limited to, addiction, overdose, and side effects.

3. Responsibilities of the Patient

- Take medications as prescribed.
- Notify the practitioner of any side effects or concerns.
- Do not share medications with others.
- Participate in follow-up appointments and assessments.
- Agree to random drug screenings if requested by the practitioner.

4. Responsibilities of the Practitioner

- Provide education regarding the use and risks of opioid therapy.
- Monitor the patient's progress and response to medication.
- Offer alternative pain management strategies as appropriate.
- Maintain confidentiality regarding the patient's treatment.

5. Agreement

By signing below, both the patient and the practitioner agree to adhere to the terms of this agreement.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____