Opioid Treatment Compliance Agreement

Date: _____

Patient Name: _____

Patient ID: _____

Provider Name: _____

Provider Signature: _____

Agreement Terms

1. I understand that I am being treated with opioid medication for my pain management.
2. I will take my medication as prescribed by my healthcare provider.
3. I will not share my medication with anyone else.
4. I will not seek prescription medications from any other healthcare providers without informing my primary provider.
5. I will participate in regular follow-up appointments and drug screenings as required.
6. I understand the risks associated with opioid medications, including dependence and overdose.
7. I agree to keep my medications in a secure location.

Signatures

By signing below, I acknowledge that I have read and understand this agreement:

Patient Signature: _____

Date: _____