KENNETH J. GALANG, M.D., P.A.
13710 METROPOLIS AVENUE, SUITE 110
FORT MYERS, FLORIDA 33912

PAIN MANAGEMENT AGREEMENT (rev 10/26/2021)

Pain Management Agreement Between_____(patient) and Kenneth J. Galang, M.D.

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient may be taking for pain management. This is to help both the patient and their provider comply with the laws regarding controlled medication.

This agreement relates to my use of controlled medication for chronic pain prescribed by Kenneth J. Galang, M.D., a physician at Rehabilitation Medicine and Pain Management Specialist. I have been informed and understand the policies regarding the use of controlled medication that are followed by the staff of Kenneth J. Galang, M.D. I understand that I may be provided controlled medication while actively participating in this program **ONLY** if I adhere to the following conditions:

1. I understand that Dr. Kenneth J. Galang and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain but to control my pain in order to improve my ability to function. Chronic Opioid therapy is only **ONE** part of my overall pain management plan.
2. I understand that Dr. Galang and I will **continually** evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication only at the **DOSE** and **FREQUENCY** prescribed by Dr. Galang. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the discontinuation of opioid therapy.
3. I will attend all appointments, treatments and consultations as requested by my provider. I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.
4. I will tell my providers about the level and description of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.
5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, injections, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in **all** aspects of the pain management program to maximize functioning and improve coping with my condition.
If treatment for my condition is available, I agree I will not refuse the treatment just so the opioids will be continued. I understand that I have the right to refuse any procedure, but that does **not** mean that Dr. Galang must continue to prescribe narcotic or opioid medications.
6. The risks and benefits of taking opioid medications have been explained to me. I understand them. Opioids can cloud judgment and affect reflexes and motor skills. I will not participate in activities that would endanger themselves or others while using these medications.
7. I agree I will not use any illegal controlled substances, including marijuana, cocaine, Heroin, etc. I agree I will not use any prescription medications obtained illegally or obtain them from friends or relatives.

PATIENT'S INITIALS: _____

8. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol.
9. I agree I will not share, sell, or trade my medication with anyone.
10. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I will report stolen medication to the police and to my provider and will produce a police report of this event.
11. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing Dr. Galang first. I agree to have my opioid prescriptions filled only at_____ (List pharmacy name and number).
12. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 4 pm, or on weekend, holidays, or through the emergency room. Medications will not be mailed or refilled without being seen at **monthly** pain clinic appointments (if patient is receiving his opioids from the pain clinic). **I understand that I can no longer pick up Scheduled narcotic medication without being seen, according to the law.**
13. I am responsible for keeping track of the number of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.
14. I agree to bring in all unused pain medicine when requested.
15. As required by law, **I will submit urine for random drug testing four times a year to determine my compliance with their program of pain control.** I agree to pay **$65.00** for Urine Drug Screening if my insurance does not cover it or if my insurance does not pay for the service. I agree to pay **$110** for the Urine Drug screening if I am Self Pay with no insurance. Refusing a urine drug test will result in being discharged from the practice.
16. I authorize Dr. Kenneth J. Galang to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
17. I will accept generic brands of my prescription medications.
18. I understand that I may become tolerant to, addicted to, or have complications from the opioid medications. If this occurs, the medication may be changed or tapered, and other methods of pain control may be used. If necessary, I will permit referral to addiction specialists.
19. If it appears to Dr. Galang that there are no demonstrable benefits to my daily function or quality of life from the controlled medication, I will agree to gradually taper my medication as directed by Dr. Galang.
20. I understand that if I violate any of the above conditions, Dr. Galang may choose to stop writing opioids prescribed for me. Discontinuation of the medications will be coordinated by Dr. Galang and may require specialist referrals.
21. I understand that if I am **verbally or physically abusive** to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the institution.
22. I Understand that suddenly stopping some pain medicines can cause problems such as: withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

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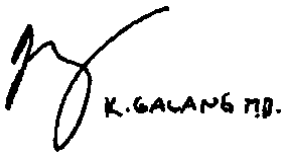
Medication Refill Information:

1. Advance notice of 4 business days is required for all **non-opioid** refills of the prescriptions.
2. Requests for scheduled refills for **non-opioids** must be telephoned to the pharmacy only during regular office hours Monday-Friday (8:30 am – 4:00 pm). Refills will **not** be made at night, on holidays, or on weekends.
3. According to the law, **prescriptions for Schedule 2 narcotics may only be picked up when you are seen by the physician.**
4. According to the law, **if you are on a Schedule 2 narcotic, Schedule 3 narcotic, or Alprazolam (Xanax), you must be seen no later than every 3 months.**
5. You will be given a (30) thirty day supply each month, if indicated.
6. All hard copies of the opioid prescriptions must be hand delivered to the pharmacy by the patient.

- **This agreement will supersede all other agreements.**
- **By signing below, I indicate that I understand AND agree to ALL the terms of the above agreement. I have received a copy of this for my own records.**

Patient _____Signature

Witness _____Signature



Provider _____Signature

Date _____

PATIENT'S INITIALS: _____