THE PEOPLE'S COMMUNITY CLINIC – PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medications you may be taking for pain management. This is to help you comply with the law regarding controlled pharmaceuticals. It is important to understand this agreement is essential to the trust and confidence necessary to the doctor/patient relationship and that my doctor will render treatment based on this agreement.

1. I understand that if I break this agreement, my doctor may choose to stop prescribing me pain management medications.
2. I will not use any illegal substances (including controlled substances) that I am not prescribed to.
3. I will not share, sell, or trade my medications with anyone.
4. I will not attempt to obtain any controlled medications from another doctor.
5. I will safeguard my medication from loss or theft. These medications will not be replaced.
6. I agree to submit to a blood or urine test if requested by the People's Community Clinic to determine compliance with the agreement. If I do not comply when asked, I will be terminated from the program.
7. I agree that if called, I will come into the People's Community Clinic & submit to a pill count.
8. I agree that I will use my medication at a rate no greater than prescribed.
9. I agree to the payment plan ($200 for initial visit, $100 for follow up visits monthly). I understand that if I do not have the payment prior to the visit, I will not be seen. I understand that the payment is for the visit itself and not the cost of a written prescription. I agree that the doctor has the right to write as he sees visit for my pain management and has the right to change prescriptions or lower the quantity given. I understand that I am still obligated to pay monthly even if the prescription given is not what I was anticipating getting.
10. I agree to the People's Community Clinic running a MAPS report to make sure I am abiding by the agreement.
11. I agree that I will make a scheduled appointment and keep that appointment. If there is an emergency, I will call prior to the appointment and reschedule it. Appointments that are no-call-no-show will not be rescheduled. I also understand that pain management is not on a walk-in basis.
12. I agree that I will not call/leave a message more than once a day. If I repeatedly call, I will be terminated from the program.
13. I understand that the People's Community Clinic only handles deals with insurance companies when they are billing insurance for a urine drug screen. They will not call my insurance on my behalf. If my insurance does not cover the cost of the medication, a new prescription or extra prescription will not be given.
14. I will not come to the People's Community Clinic office unless I have an appointment.

I AGREE TO USE _____

ZIP CODE/TELEPHONE NUMBER _____

I agree to the following guidelines. My signature below is verification of my agreement and compliance to the program. If I break any of these agreements, I will be terminated from the program.

PATIENT NAME (PRINTED) _____

PATIENT SIGNATURE _____

DATE OF AGREEMENT SIGNED _____/_____/20_____

WITNESS SIGNATURE _____

1373 E. LAKETON AVE., SUITE B, MUSKEGON, I 49442
TELEPHONE (231)766-7604 – FAX NUMBER (231)766-7603

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.)
(Do NOT include eye conditions that you have previously listed.)

Condition	Month/year diagnosed

Please list all previous surgical procedures (not involving eyes) and their dates (if known):

Surgical Procedure	Month/year

MEDICATIONS:
Please list all medications that you are currently taking and their dosage (if known):

Medication	Dose	# of times per day	For how long

Are you taking aspirin or any other over-the-counter medicines? No ___ Yes ___

If yes, please list: _____

_____

Do you have any known drug allergies? No ___ Yes ___

If yes, please list: _____

_____

_____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	NO	YES
General		
Fever	___	___
Unexplained weight loss	___	___
Night sweats	___	___
Ear, nose, or throat		
Ringing in ears	___	___
Hearing Loss	___	___
Pain	___	___
Nervous System		
Headache	___	___
Stroke	___	___
Seizure/epilepsy	___	___
Weakness, numbness, tingling	___	___
Heart or circulatory problems		
Heart attack or heart failure	___	___
Irregular heart rhythm	___	___
Chest pain	___	___
Pacemaker	___	___
Hypertension	___	___
Endocrine		
Thyroid disease	___	___
Diabetes	___	___
Hormonal disease	___	___
Allergy/Immunology		
Environmental allergies	___	___
Iodine allergy	___	___
Contrast material (dye) allergy	___	___
Cat scratch or cat bite	___	___
Skin/breast		
Masses/tumors	___	___
Rash	___	___
Discharge from breast	___	___

	NO	YES
Lungs/Breathing		
Breathing difficulty	___	___
Asthma	___	___
Lung disease	___	___
Digestive System		
Diarrhea	___	___
Ulcer disease	___	___
Hepatitis	___	___
Genitourinary		
Kidney disease	___	___
Urinary tract infection	___	___
Urinary bleeding	___	___
Altered menses	___	___
Blood		
Anemia (low blood count)	___	___
Blood tumors/disease	___	___
Swollen glands	___	___
Bleeding disorder	___	___
Musculoskeletal		
Joint pain/arthritis	___	___
Fractured bones	___	___
Pain with chewing	___	___
Scalp pain/tenderness	___	___
Psychiatric		
Depression	___	___
Mood swings	___	___
Anxiety	___	___
Admission to hospital/ psychiatric illness	___	___
Other:		

_____

_____

COMMENTS: _____

_____

_____

	My	Yes	No	Yes
Depression				
Fever	___	___	___	___
Excessive weight loss	___	___	___	___
Night sweats	___	___	___	___
Lymph nodes enlarged				
Coughing up pus	___	___	___	___
Coughing blood	___	___	___	___
Pain	___	___	___	___
Nervous system				
Muscle aches	___	___	___	___
Seizures	___	___	___	___
Severe headache	___	___	___	___
Stiff neck, numbness, tingling	___	___	___	___
Loss of consciousness or coma	___	___	___	___
Heart attack or severe failure	___	___	___	___
Irregular heart rhythm	___	___	___	___
Chest pain	___	___	___	___
Pericarditis	___	___	___	___
Endocarditis	___	___	___	___
Lungs				
Pneumonia	___	___	___	___
Chronic cough	___	___	___	___
Asthma	___	___	___	___
Shortness of breath	___	___	___	___
Pulmonary embolism	___	___	___	___
Pleural effusion	___	___	___	___
Stomach				
Nausea	___	___	___	___
Vomiting	___	___	___	___
Diarrhea	___	___	___	___
Abdominal pain	___	___	___	___
Liver disease	___	___	___	___
Gallbladder	___	___	___	___
Pancreas	___	___	___	___
Kidneys				
Kidney disease	___	___	___	___
Urinary tract infection	___	___	___	___
Urinary bleeding	___	___	___	___
Altered menses	___	___	___	___
Blood				
Anemia (low blood count)	___	___	___	___
Blood clots, deficiency	___	___	___	___
Swollen glands	___	___	___	___
Bleeding disorder	___	___	___	___
Musculoskeletal				
Joint pain/arthritis	___	___	___	___
Tumor/cancer	___	___	___	___
Jaw and/or chewing	___	___	___	___
Bone pain/tenderness	___	___	___	___
Skin				
Rash	___	___	___	___
Ulcers	___	___	___	___
Mood swings	___	___	___	___
Anxiety	___	___	___	___
Admission to hospital				
Other illness				
Other				

1. Patient's Name: _____
   (First name, Middle Initial, Last Name)
2. Date of Birth: _____ Male or Female
3. Mailing Address: _____
4. City, State, Zip: _____
5. Email Address: _____
6. Phone Number: _____ Alternate: _____
7. Home address: _____

   _____
8. What would you like our clinic to assist you with: _____
9. How did you hear about our clinic: _____

Patient signature acknowledging that the information they provided is valid.

Patient's Signature:

_____

Witnessed by:

_____

Date:

_____

In order to be seen by our doctor, one must have a valid form of photo identification (state ID or driver's license) and medical documentation that shows a chronic or qualifying condition. If one is to be seen for pain management, one also needs medical documentation that shows prescriptions name, dosage, and length of time one has been on that prescription. We reserve the right to refuse service to anyone. A medical marijuana certification, renewal, or pain management medication is not a guarantee because one is seen by a doctor. All decisions are made by the D.O. and they are final.