Wellness First Pain Management

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Tennessee State Pain Management Certification Number: 00000309 expires; 10/31/2014

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Pharmacy: I agree to fill my prescriptions ***only*** at the pharmacy I list below. If I change pharmacies or my pharmacy does not have the prescribed medication in stock and will not have it by the time I run out of my current prescription, I will contact the Wellness First Pain Management office and provide them with the name, address and phone number of the new pharmacy.

I understand and consent for my prescriptions to be sent to my pharmacy electronically whenever possible. By sending the prescription electronically, I am less likely to lose my prescription or to have my prescription stolen, and there is no chance that the prescription can be altered or changed. When electronic transmission of my prescription is not possible, I understand that my prescription will be printed on security paper that prevents alteration, photocopying, or other tampering.

Under no circumstances will I obtain Opioid medications from more than one pharmacy at a time, as doing so is a felony offense. In order to verify appropriate medication use, my Healthcare Provider's office will provide my chosen pharmacy with a copy of this agreement. My signature below provides my consent to provide a copy of this agreement to my pharmacy.

I understand that any alteration in my medication prescriptions may require a new written agreement.

Pharmacy name _____

Pharmacy address _____

Pharmacy telephone _____

Medication name, dose and directions _____

Number of pills prescribed _____ Frequency of appointments _____ days

I understand that by signing this agreement, I am acknowledging that I understand the many potential risks and benefits of using Opioid pain medication, the potential side effects of this medication, and that I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my Healthcare Provider and Wellness First Pain Management.

My signature below indicates that I have read this form or have had it read to me, and that I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily, and I give my consent for the treatment of my pain with Opioid pain medication (as well as any non-Opioid medication that my Healthcare Provider has prescribed to me).

_____ ___/___/___

Patient signature Date

_____ ___/___/___

Healthcare Provider signature Date