

*Danya A. Godoy, M.D.*  
*Department of Pain Management*

**MEDICATION AGREEMENT AND PAIN TREATMENT PROGRAM**

This agreement between \_\_\_\_\_ (patient) and Danya A. Godoy M.D. of Suncoast Medical Clinic, LLC (SMC) is for the purpose of establishing clear conditions between the physician and the patient regarding prescribed medications as part of your treatment at SMC. This program may include care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (i.e. psychology, psychiatry, coping strategies, biofeedback), alternative therapies, physical therapy and the prescription and use of medications. The physician and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship.

As a consultant in pain management, I will recommend and/or initiate therapy for your pain condition. A reduction in the intensity of your pain and improvement in your quality of life are the goals of this program.

I agree to and accept the following conditions for my pain treatment program, which may include medication prescribed by Dr. Danya A. Godoy:

- \_\_\_\_\_ 1. I understand that strong medications, which may include opioid and other controlled substances, may be prescribed for pain relief. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose or opioid medication may cause injury or death by stopping breathing. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, and loss of appetite, confusion, and sweating, flushing, depressed respiration and reduced sexual function.
- \_\_\_\_\_ 2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve.
- \_\_\_\_\_ 3. I realize that all medication have potential side effects and interactions. I understand and accept that there may be unknown risks associated with long-term use of substances prescribed.
- \_\_\_\_\_ 4. I understand that if I am pregnant or become pregnant while taking medications, my child could become physically dependent on the opioids, and withdrawal can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with medication from Dr. Danya A. Godoy. Many medications could harm the fetus or cause birth defects.

- \_\_\_\_\_ 5. I understand I must contact my pain physicians before taking tranquilizers or prescription sleeping medication. I understand that the combined use of various drugs, opioids, as well as alcohol may produce confusion, profound sedation, respiratory depression, blood pressure decrease and even death.
- \_\_\_\_\_ 6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.
- \_\_\_\_\_ 7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.
- \_\_\_\_\_ 8. Timely requests for refills of medications are the patient's responsibility.
- a. **Refills will be made ONLY during scheduled appointments. Refills will not be made over the phone, at night or on weekends. This policy is strictly adhered to.**
- b. Refills will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed for keeping track of the amount remaining.
- \_\_\_\_\_ 9. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with Dr. Danya A. Godoy
- \_\_\_\_\_ 10. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed by Dr. Danya A. Godoy
- \_\_\_\_\_ 11. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by Dr. Danya A. Godoy.
- \_\_\_\_\_ 12. I understand that once my pain management is optimized, refill of my medications may be transferred to my primary care physician. If I do not have a primary care physician at the time, I will have from 1-3 months to find a physician that will take over my care and prescribe my medications.
- \_\_\_\_\_ 13. I understand the main treatment goal is to improve my ability to function and/or work and/or to reduce pain. In consideration of that goal and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.



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\_\_\_\_\_ 14. Dr. Danya A. Godoy and I agree that this agreement is important to my physician's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my physician and termination of the physician/patient relationship.

**I have thoroughly read and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by Dr. Danya A. Godoy. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain treatment program. I also agree to testing and detoxification, if indicated.**

If at any time you are concerned about your medication or side effects of your medication, you may call the clinic at 727-824-8383. The on-call physician can also be contacted to receive your message, if necessary.

I agree to use \_\_\_\_\_ pharmacy, located at \_\_\_\_\_, telephone number \_\_\_\_\_, for all my pain mediations. If I change my pharmacy for any reason, I agree to notify SMC at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

_____ Patient Name (Please print)	_____ Patient Signature	_____ Date
_____ Physician Name (Please print)	_____ Physician Signature	_____ Date
_____ Witness Name (Please print)	_____ Witness Signature	_____ Date