STEVEN C. DICKHAUT, M.D.
4800 NE STALLINGS DR.
SUITE 110
NACOGDOCHES, TX 75965

MEDICATION MANAGEMENT AGREEMENT

I, ______________________________, understand that this agreement is between Steven C. Dickhaut, M.D. and myself. It is designed to inform me fully of the manner in which my medications, especially narcotics, will be provided. It also outlines the criteria by which the doctor will determine whether or not to continue my medication. I understand that a reduction on the intensity of my pain and an improvement in my quality of life are the goals of this program.

1. Pain medications, especially of a narcotic type, will be provided only after it is determined that all reasonable alternatives for adequate pain control have been investigated/attempted.

2. I will agree to try other techniques as felt appropriate by the Doctor or Physician Assistant that may assist me in taking the lowest effective dose possible.

3. My "pain medications" will be prescribed by one doctor and one doctor only, and filled at one pharmacy. Any attempt, successful or not, to obtain additional medication without the permission of the doctor may result in discontinuation of medication therapy.

4. I agree to notify the doctor's office if I change my pharmacy for any reason.

5. Medications will be given at fixed intervals, and only if I keep my doctor appointments.

6. I understand no refills will be made after office hours or on weekend/holidays.

7. I agree that I will use my medication at a rate no greater than the prescribed rate and use of my medication at a greater rate will result in my being without medication for a period of time.

8. If your narcotics are lost or stolen, they will not be refilled until the due date.

9. Doctor and Patient agree that this agreement is essential for the Doctor's ability to treat the patient's pain effectively and that the failure of the patient to abide by the terms of this agreement may result in the withdrawal of my medication and the termination of the Doctor/Patient relationship.

I have read and understand each of the above statements. I realize that he doctor will assume the responsibility of assisting me in my therapy as long as I comply with the above.

___________________________________ ________________________
Patient/Guardian Signature **Relationship to patient**

___________________________________ ____________________
Witness Signature **Date**