



AESTHETIC FACIAL PLASTIC SURGERY PLLC  
DR. PHILIP YOUNG, MD

### **Pain Management Agreement**

I understand that I have a right to comprehensive pain management along with the surgery that I will undergo. I wish to enter into a treatment agreement to prevent possible chemical dependency. I understand that failure to follow any of these agreed statements might result in Aesthetic Facial Plastic Surgery, PLLC ("AFPS") and Dr. Philip Young to not provide ongoing care for me.

I, \_\_\_\_\_, agree to undergo pain management by Aesthetic Facial Plastic Surgery, PLLC. Pain Management provided by AFPS is for the purpose of post-operative plastic surgery. I agree to the following statements:

- I will not accept any narcotic prescriptions from another doctor unless approved by all physicians.
- I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications will cause severe withdrawal syndrome.
- I will only take the medication as directed by AFPS.
- I understand that I must keep my medications in a safe place.
- I understand that AFPS will not supply additional refills for the prescriptions of medications that I may lose.
- If my medications are stolen, AFPS will refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.
- I will not give my prescriptions to anyone else.
- I will only use one pharmacy.
- I will keep my scheduled appointments with AFPS unless I give notice of cancellation 24 hours in advance.
- I understand that pain medications can affect my breathing and could lead to life threatening situations if I am not careful. I understand that I should not take too much medication that I am too tired or drowsy that will lead me to stop breathing and result in death. I understand that I have a maximum amount that I can take in a 24 hour period but that some people respond differently and this maximum may be less than what is stated and that I need to see how the medication is affecting me.
- I understand that if there is any question or concern regarding taking pain medications or taking too much pain medication then I will contact Dr Young immediately or call 911.
- I agree to refrain from all mind/mood altering/illicit/addicting drugs including alcohol unless authorized by AFPS.

My treatment plan may change based on outcome of treatment, especially if pain medications are ineffective. Such medications will be discontinued.



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My treatment plan includes:

Medications: \_\_\_\_\_

Physical therapy/exercise: \_\_\_\_\_

Relaxation techniques: \_\_\_\_\_

Psychological counseling: \_\_\_\_\_

I understand that AFPS believes in the following "Pain Patients' Bill of Rights."

You have the right to:

- Have your pain prevented or controlled adequately.
- Have your pain and medication history taken.
- Have your pain questions answered.
- Know what medication, treatment or anesthesia will be given.
- Know the risks, benefits and side effects of treatment.
- Know what alternative pain treatments may be available.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive pain medication on a timely basis.
- Refuse treatment without prejudice from your physician.
- Include your family in decision-making.

**Termination Clauses**

- The doctor may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement. Proof or verification of such beliefs is not required for termination and discontinuation of care.
- I understand that I may terminate this agreement at any time.
- If the agreement is terminated, I will not be a patient of AFPS or Dr. Philip Young and would strongly consider treatment for chemical dependency if clinically indicated.

\_\_\_\_\_  
Patient/Guardian Signature Date: \_\_\_\_\_

Print Patient/Guardian Name: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature Date: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_