

AMERICAN ACADEMY OF PAIN MANAGEMENT

Prescribing Issue

Treatment Attestation for Pain Management

Treatment Attestation for Pain Management Services

I, _____ (patient's name) _____, am seeking healthcare services for the treatment of my painful condition from _____ (practitioner's name) _____. I understand that my accuracy, completeness and truthfulness in reporting my history and symptoms will directly contribute to the development of my treatment plan and the improvement in my painful condition. I acknowledge that I intend to provide all necessary releases for healthcare information so _____ (practitioner's name) _____ may receive my previous healthcare records from other clinicians. I know that if I am not accurate, complete and truthful in providing my history and symptoms _____ (practitioner's name) _____ cannot safely treat me for my painful condition.

I intend to disclose the names of all prior treating practitioners and to inform _____ (practitioner's name) _____ about all current prescribers of controlled substances. I do not intend to seek medications for any purposes other than my personal medical needs. I will not deliberately misrepresent my history, prevent _____ (practitioner's name) _____ from obtaining my previous medical records, fail to inform _____ (practitioner's name) _____ about the existence of other sources of prescription medication, or allow anyone other than myself to take medications prescribed to me. I understand that obtaining controlled substances (prescription medicines) through false representations is a crime and that I will be reported to law enforcement officials for attempting to fraudulently obtain these medications for non-therapeutic purposes.

I am seeking treatment for the purpose of reducing or relieving my pain. I am not appearing to seek care from _____ (practitioner's name) _____ as part of an ongoing investigation of _____ (practitioner's name) _____. I am a legitimate patient voluntarily seeking healthcare services for a painful condition.

(Patient's signature)

(Witness' signature)

(Patient's printed name)

(Witness' printed name)

_____/_____/200____

_____/_____/200____

