CONFIDENTIAL

INFORMED CONSENT AGREEMENT

AND

PAIN MANAGEMENT AGREEMENT

NAME OF PATIENT:_____ **DATE:** _____ **DATE OF BIRTH:** _____

INFORMED CONSENT AGREEMENT

TO THE PATIENT, AND/OR PATIENTS DESIGNEE, SURROGATE OR GUARDIAN: As a patient, you have the right to be informed about your condition and the recommended medical, diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug or allow a procedure after knowing the therapeutic results desired; and the risks and hazards involved as well as applicable alternative treatments, if any. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the dosage of drug(s) recommended to you by me, as your physician or to authorize the procedure, or both. For the purpose of this agreement the use of the word "physician" is defined to include not only me as your physician but also my physicians' authorized associates, technical assistants, nurses, staff and other health care providers as might be necessary or advisable to treat my condition and as may be medically proper and appropriate.

TRANSLATION IF REQUIRED: This Informed Consent has been explained to me in a language I understand verbally and in written form, or it has been translated to me by a person known to me to be fluent in both languages, written and verbal.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (named at the end of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) and/or to conduct therapeutic procedures, if applicable, as an element in the treatment of my chronic pain.

I understand that these medication(s) may include opiate/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The applicable alternative methods of treatment, if any, the possible risks involved and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions and that death is also a possibility as a result of taking these medication(s). Applicable alternative therapies (in addition to or instead of drug therapy), including but not limited to physical therapy or psychological techniques have also been explained to me.

OFF LABEL USE OF MEDICATION: THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS MAY INLCUDE THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT MAY HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN THE APPLICABLE RISKS AND BENEFITS OF OFF LABEL USE OF ANY MEDICATION AND DOCUMENT THE SAME IN MY MEDICAL CHART.

Patient's Initials _____

MEDICAL, DRUG AND OTHER TESTING: I have been informed and understand that I will undergo medical tests and examinations before and during my treatment. Those tests may include random unannounced check for drugs and psychological evaluations if and when it is deemed necessary by my physician. I hereby give permission to perform medical tests, drug tests, and/or psychological tests including the taking of body fluid as may be directed or determined to be necessary by the physician at any time. Any refusal by me to test, be examined, to undergo any procedure, or refusal to see a referral healthcare provider recommended or prescribed by the physician may lead to termination of my treatment. The discovery of the presence and/or use of any unauthorized substances by me, or as shown on a toxicology scan, test or report may result I my being discharged from the physician's care.

FOR FEMALE PATIENTS ONLY: Please check (✓) the appropriate answer;

(___) To the best of my knowledge I am **NOT pregnant.** Further, I agree that I will use appropriate contraception/birth control during the course of treatment. I accept that it is my responsibility to inform my physician immediately at the earliest time available, if I plan on or become pregnant.

(___) To the best of my knowledge I **AM pregnant or I am uncertain.** If uncertain, I WILL NOTIFY MY PHYSICAN IMMEADIATELY when I think that I might be pregnant and when the pregnancy is confirmed. All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have been enough studies conducted on the long-term use of many medication(s) i.e. opiates/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

(___) **I AM BREASTFEEDING A BABY.** All of the above possible side effects of medication(s) have been fully explained to me and I understand that, at present, there have been enough studies conducted on the long term use of many medication(s) i.e. opiates/narcotics to assure complete safety to my feeding child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the baby.

FOR ALL PATIENTS: I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmia (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence, addiction or even death. I also understand that impairment of my motor skills may occur and it may be dangerous for me to operate an automobile or other machinery while using these medications and my judgment may be impaired during all activities, including work. I agree to notify my physician immediately of any side effects from taking the medication(s). I agree to read all literature provided by the manufacturer of the medication and any additional information about the medication provided by pharmacist and/or by the physician, if any, I will discuss any questions I may have about the literature with my physician.

The goal of my treatment is to attempt to gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure or complete pain relief, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment may require prolonged or continuous use of medication(s), and also that an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored especially for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will immediately notify my physician of any discontinued use of medications prescribed by this or any other doctor outside this practice. I also understand and acknowledge that I have been made aware of possible effects of stopping the use of the prescribed drug(s).

Patient's Initials _____

The physician will provide medical supervision, if needed, when discontinuing medication use. If I chose not to be provided with medical supervision, I will hold the physician harmless for any negative results.

I understand that no representation, warranty or guarantee has been made to me as to the results of any proposed drug therapy, cure of any condition or potential or total relief from pain. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treat my condition, the risks and hazards of such drug therapy, treatment and procedure(s), and applicable alternative therapies, if any. I believe that I have sufficient information to give this informed consent and I represent that all my questions have been answered.

The applicable alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

PAIN MANAGEMENT AGREEMENT

IN ADDITION TO THE CONSENT ABOVE, I ALSO UNDERSTAND AND AGREE TO THE FOLLOWING:

This Pain Management Agreement relates to my use of any and all medication(s) (i.e., opioids, also called narcotics, painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding and strictly limiting the use and prescribing of controlled substance(s). **Therefore, I understand and acknowledge that medication(s) will only be provided so long as I follow the rules specified in this agreement and the terms of any prescription that I may receive.**

My physician may at any time choose to discontinue the medication(s) in physician sole discretion. Failure to comply with any of the following rules may cause discontinuation of medication(s) and/or any discharge from care and treatment. Discharge will be immediate for any criminal behavior.

- My progress will be periodically reviewed and, if the medication(s) do not appear to be improving my quality of life, in my physician's opinion, the medication(s) may be discontinued, altered, or changed.

- I will disclose to my physician all medication(s) that I take at any time, prescribed by any other doctor, dentist or healthcare provider. Disclosure is required for all medications, prescriptive and non prescriptive and for pain, or for non pain medication, including any anti anxiety medication.

- I will disclose to my physician all over-the counter supplements, herbs, pills, ointments, patches or other aids or substances that I take or use for any reason, at any time.

- I will use the medication(s) exactly as prescribed by my physician. Any discrepancy between the prescription and the medication bottle shall be brought the attention of the physician immediately.

- I agree not to share, sell or otherwise permit others, including my family or friends to have access to or ingest my medications at any time.

- I will not allow or assist in the misuse, abuse, or diversion of my medications nor will I give or sell them to anyone at any time for any reason.

Patient's Initials _____

- All medication(s) prescribed by this physician, and any pain medication, irrespective of who prescribes them, must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies; my physician must be promptly informed. I will provide my pharmacist with a copy of this agreement. I authorize my physician to consult with and to release my medical records to my pharmacist as needed.

- I understand that my medication(s) will be refilled on a regularly scheduled basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may not be replaced.

- Refill(s) will not be ordered before the scheduled refill date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. This applies to weekends and holidays as well.

- I will receive pain medication(s) from only ONE physician unless it is for an emergency or the medication(s) that is being prescribed by another doctor is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to an immediate discontinuation of medication(s) and treatment.

- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try applicable alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuance of medication(s).

- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning or notice. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, any street drugs, or positive for any pain medications, or any other ancillary medication not authorized by the physician, treatment may be terminated. Also, I consent and agree to consult with, or refer to, an expert which may be necessary; such as submitting to a psychiatrist or psychological evaluation by a qualified doctor such as an addictionologist or a doctor, whom specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy should the physician recommend and prescribe such. I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and/or other alternative medical care.

- I recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of my pain management program as recommended by my physician to attempt to achieve increased function and improved quality of life.

- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause adverse effects with pain medications and even cause harm.

- I hereby give my physician permission to discuss all diagnostic and treatment details with my primary care doctor(s), pharmacist(s), and any other treating healthcare provider regarding my use of medications prescribed by my physician(s) or by other doctors.

- I agree to take the medication(s) precisely as instructed by my physician. Any unauthorized increase in the dose of medication(s) or the method of taking the medication or the frequency of taking the medication may be a cause for discontinuation of the treatment by my physician.

Patient's Initials _____

- I agree to keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

- I agree to keep all follow-up appointments with any other medical care provider prescribed or recommended by my physician or my treatment may be discontinued.

I certify, represent and warrant that:

1) I am not currently using illegal drugs or abusing prescription medication(s) and that I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment. I have read all five pages of this document before signing it.

2) I am not and have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, or other drugs or narcotics) or other medications.

3) No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment and to this Pain Management Agreement.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain, including any off label use of medications. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I voluntarily and knowingly agree to the use of these medication(s) in the treatment of my chronic pain.

Read, agreed and accepted on the date first written above by:

Patient Signature: _____ Date: _____

Patient's designee, surrogate or guardian:

Signature: _____

Typed/Printed Name: _____

Relationship to Patient: _____

Telephone Number: _____

Name of Pharmacy: _____

Address: _____

_____

Telephone Number: _____

- I agree to keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

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