INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED FOR LONG-TERM CONTROLLED SUBSTANCE THERAPY

NAME OF PATIENT:____ DATE: ________________

For the purpose of this agreement the use of the word "medical provider" is defined to include not only my physician but also my physician's authorized associates, technical assistants, physician's assistants, nurse practitioners, staff, and other healthcare providers as might be necessary or advisable to treat my condition.

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. 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 drug(s) recommended to you by me, as your medical provider.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my medical provider (name at bottom 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 medical provider to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/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 alternative methods of treatment, 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 from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY MEDICAL PROVIDER PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAT WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests, examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my medical provider immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY MEDICAL PROVIDER IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) (i.e opioids/narcotics) to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my medical provider harmless for injuries to the embryo/fetus/baby.

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, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The 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.

The goal of this treatment is to help me 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, 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 for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically 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 notify my medical provider of any discontinued use beforehand. I further understand that I will be provided medical supervision when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. 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 treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That 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, etc.) for chronic pain prescribed by my medical provider. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My medical provider may at any time chose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- **I will treat all staff at CVPM respectfully at all times.** I understand that if I am disrespectful to staff it may be grounds for permanent discharge from the practice and I will be responsible for finding a new medical provider.
- I will **disclose** to my medical provider **all medication(s)** that I take at any time, prescribed by any medical provider.
- I will use the medication(s) **exactly as directed by my medical provider and pharmacist. I will not mix alcohol my prescriptions as it is potentially harmful to my health.**
- I agree **not to share**, sell or otherwise permit others, including my family and friends, to have access to these medications.
- When needed, I designate ___________________________________ to pick up my prescriptions.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else. I agree **not to use any medication(s) that are not prescribed to me, including medication(s) from family, friends or relatives.**
- All medication(s) must be obtained at **one pharmacy, where possible.** Should the need arise to change pharmacies, my medical provider must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my medical provider to release any medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular 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 released 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. No other medication will be prescribed in place of lost or stolen medications.
- I will receive medication(s) **only from ONE** medical provider unless it is for an emergency or the medication(s) that is/are being prescribed by another medical provider is approved by my medical provider. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my medical provider may lead to a discontinuation of medication(s) and treatment.
- If it appears to my medical provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), **then my medical provider may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my medical provider liable for problems caused by the discontinuance of medication(s).
- **I agree to submit to random urine and/or blood screens, and pill/patch counts within the specified time** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as methamphetamines, heroin, cocaine, etc., or negative for all prescribed medications, treatment for chronic pain may be terminated. Also a referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified medical provider such as an addictionologist or a medical provider who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I understand that the results of these drug screens will include all pain medications prescribed to me and any other drugs in my system, **including all street drugs, alcohol and any other medications taken illicitly.** These results will become part of my medical chart and will be sent to insurance carriers, if requested.

- I recognize that my chronic pain represents a complex problem which may benefit from the physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my medical provider 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. In order to reduce risk of adverse effects from medications and interactions.
- I agree to notify my medical provider of any narcotic medications prescribed to me by another medical provider. **Again prior consent from a CVPM medical provider will be required if another physician must prescribe any new/additional pain medication(s).**
- I hereby give my medical provider **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my medical provider. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my medical provider or my treatment may be discontinued.
- I understand that I will need to have an appointment in order for pain medications to be refilled. I understand that refills will not be given simply because an appointment is missed or cancelled.
- **MEDICATION HISTORY:** I authorize CVPM to download my medication history and prescription benefits into my account from a prescription clearinghouse to help prevent adverse medication interaction and to keep you safe.

I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and 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.
2. I will **never be involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (cocaine, heroin, etc.)
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, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain. Any failure to follow the policies set by CVPM may result in permanent discharge from the practice.**

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Patient Signature

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Medical Provider Signature (or Appropriately Authorized Assistant)

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Name and contact information for pharmacy