COMPLEX PAIN & WELLNESS®

INFORMED CONSENT AND PAIN MEDICINE AGREEMENT

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 (medication) therapy to be used, so that you may make an informed decision whether or not to take the drug(s) 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 physician. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your physician's expectations that are necessary for patient compliance. For the purpose of this agreement the use of the word "physician" is defined to include not only your physician but also your physician's authorized associates, physician assistants, nurse practitioners, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat your condition.

Chronic Narcotic Contract:

If you have agreed to take narcotic pain medication for your pain, you understand to maximize your safety, and you agree to follow your physician's direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy. The purpose of this treatment is to help you gain control of your pain and to improve your level of function. Alternative therapies have been fully explained and offered. You realize that you may have a chronic illness and the treatment may require prolonged or continuous use of medications, but an appropriate treatment goal may also mean the eventual withdrawal from use of the medications or an alternative therapy. Your treatment plan is tailored for you specifically. If you decide to withdraw from this treatment plan, you will need to notify the physician as this will require medical supervision.

The risk of taking narcotic pain medication and the rules for obtaining prescriptions are listed below. By signing this contract, you agree to these risks and agree to follow all the rules of the clinic without exceptions.

Risks of Chronic Narcotic Therapy:

Patients taking narcotics can become physically dependent on these medicines. Dependent means your body becomes accustomed to receiving these medicines. Therefore, sudden discontinuation of these medicines may lead to possible side effects such as dizziness, nausea, abdominal pain, blood pressure problems and even seizures. Do not suddenly stop taking your medicines.

Addiction is psychological dependence. The risk of addiction is low when pain medications are used appropriately. However, becoming addicted to pain medicines is always a possibility even when taking pain medications for medical reasons.

Other side effects include but are not limited to the following: mood changes, drowsiness, constipation, and nausea. If you become pregnant, there is a risk of physical dependence to narcotic to the unborn child.

Warnings:

If you become pregnant, please notify your physician immediately. Please do not drive while taking your pain medication. Be careful whenever participating in any activity that requires concentration or coordination as your reflexes and reaction times may be slowed even if you do not notice it.

You 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 (including "off-label" prescribing) to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. You have been given the opportunity to ask questions about your condition and the treatment risks and options so you can give an informed consent.

Rules of the Clinic:

You must fill your prescription from the same pharmacy every time. You will not receive pain medication from any other physician. If you receive medicines from the emergency room, or from another procedure, please notify us. No refills will be prescribed early. No "emergency" refills will be done in the evening, Friday afternoon, or on weekends.

Medical Tests and Drug Screening:

You have been informed and understand that you will undergo randomized urine and/or blood screens and psychological evaluations during your treatment as deemed necessary by your physician at any time and without prior warning. You give permission to perform these tests and understand your refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in your being discharged from your physician's care and given the appropriate notice to seek care elsewhere. Be aware that controlled substances are now being monitored by the Texas State Board of Pharmacy and are accessed by your physician every time a prescription is written.

Illicit Drug use:

Any or all positive illicit drug screening will require psychological / addiction evaluation as well as immediate taper from Narcotic analgesia.

Consent to Treatment and/or Drug Therapy:

I have read the contract and agree to abide by all the rules of the clinic. I have read all the risks of taking pain medicines (dangerous and/or controlled substances) and have been given the opportunity to ask questions. This agreement relates to my use of any and all medications called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics, painkillers and other prescription medications). I understand that there are many strict federal and state laws and regulations and policies regarding the use and prescribing of controlled substances. Therefore, medication will only be provided so long as I follow the rules specified in this agreement. I also understand it is up to the examining physician's discretion to maintain and/or terminate my care with an appropriate 30-day notice without cause. Discharge may be immediate for any criminal behavior. I voluntarily accept the risks and conditions of the proposed treatment plan.

Patient's Signature:_____ Date: _____

Witness Signature: _____ Date: _____