Sports & Spine
Pain Management

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure of 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 Physician. For the purpose of this Agreement the use of the word "Physician" is defined to include not only Hyon K. Schneider MD but her authorized associates, technical assistants, nurses, staff and other health care providers as might be necessary or advisable to treat your condition.

Name of Patient: _____ (I, me, my) Date:_____

INFORMED CONSENT:

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request Physician to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for Physician 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 but are not limited to opioid/narcotic drug(s), muscle relaxers, anti-inflammatories, sedatives, 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 PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). PHYSICIAN WILL EXPLAIN HER TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I have been informed and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced check for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in discontinuation of medications and/or being discharged from Physician's care.

For female patients only:

To the best of my knowledge **I AM NOT PREGNANT.**

If at any time there is a concern or suspicion that I am pregnant from Physician, I agree to a pregnancy test.

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 Physician immediately if I become pregnant.

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

All of the below 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 Physician harmless for injuries to the embryo/fetus/baby. I understand that the use of opioid

medications during pregnancy may result in giving birth to a child that is physically dependent on controlled substances.

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 (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heart beat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing) impotence, tolerance to medication(s), physical and emotional dependence or even addiction. In men, chronic opioid therapy has been associated with low testosterone levels, which may affect mood, stamina, and sexual desire, physical and sexual performance. I understand that use of alcohol, sedatives, or illicit substances may increase certain side effects and will avoid the use of these substances.

I understand that it may be dangerous for me to operate a motor vehicle or other machinery while using these medications and I may be impaired during all activities including work. I understand that these medications may decrease reflexes or slow reaction time. I understand that medications for chronic pain may interfere with my ability to participate in certain activities and may result in dangerous situations if I am drowsy or impaired. I agree to NOT participate in these activities while using my medications. Examples include, but are not limited to, using machinery or heavy equipment, operating a motor vehicle, working at unprotected heights, using power tools, firearms, weapons, or being responsible for another person such as a child or older adult.

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 I will notify Physician of any discontinued use. I further understand that I will be provided medical supervision if needed 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 and therapeutic 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 Physician. 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 the Agreement.** I understand the discontinuation of opioid medications may result in "withdrawl" syndrome which may be uncomfortable, but not life threatening.

Physician may at any time choose 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 **disclose** to Physician **all medication(s)** that I take at any time, prescribed by any physician.

I will use the medication(s) **exactly as directed by Physician**.

I agree **not** to share, sell or otherwise permit others, including my family and friends, to have access to these medications.

I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone.**

All medication(s) must be obtained at **one pharmacy, when possible**. Should the need arise to change pharmacies the Physician must be informed. I authorize Physician to release my medical records to my pharmacist as needed.

I understand that my medication(s) may be eligible for refills on a regular basis. I understand that my prescription(s) and my medication(s) **If lost or stolen, they may NOT BE REPLACED.** I understand it is my responsibility to protect these medications from theft or damage, and that a locked box or safe is recommended by physician for this purpose.

Refills **will not be ordered before the scheduled refill date, i.e. no early refills**. 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. I will not increase the dose or frequency of use of my medications as I realize I will run out and they will **not** be replaced.

I will receive pain medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) prescribed by another physician are approved by Physician. Information that I have been receiving medication(s) prescribed by other doctors that have not been approved by Physician may lead to a discontinuation of medication(s) and treatment. I must come to my schedule appointment for my medication(s) as medication(s) will not be called into your pharmacy.

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

I agree to submit to urine, saliva and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. Refusal to submit to compliance testing or tampering with testing may result in discontinuation of medications and or discharge from the practice. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc. treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specialized in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, interventional procedures (injections etc), referral to a chronic pain management program, 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 Physician 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 harm.

I hereby give Physician **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 Physician. **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 Physician or my treatment may be discontinued.

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 have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or pain killers) or illegal substances (marijuana, 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 the medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

5. I acknowledge that I have received a copy of this agreement and have read it and understand it. I have asked any questions that I might have about this agreement and understand all of my questions.
6. I hereby authorize Sports & Spine Pain Management to access my Medication History, as well as to cooperate with any city, state, federal law enforcement agency or authority, including the Maryland Board of Pharmacy in the investigation of or possible sale, misuse, or diversion of medication.

Patient Signature _____ Date _____

Physician Signature _____