



COMPREHENSIVE PAIN

MANAGEMENT SPECIALISTS

PAIN MANAGEMENT PROGRAM PARTICIPATION AGREEMENT AND CONSENT

Pain may be effectively managed through the use of controlled substance medications (referred to below as “opioids”). However, even when being administered by an experienced and competent physician, opioids may be misused and abused and may result in physical dependence or addiction. Due to the possibility of misuse, abuse and addiction, opioids are closely controlled by local, state and federal governments and may be prescribed or administered only after generally accepted medical procedures have been tried and offer no relief or cure of the pain.

You must carefully read the Pain Management Program Participation Agreement and Consent (the “Agreement”). By signing this document you confirm that you are fully informed about and consent to the pain management program (the “Pain Program”) prescribed by your treating pain physician (referred to below as your “Physician”), that you understand that side effects may, and often do, occur, and that you agree to follow all of the Pain Program rules, including those not specifically stated in this Agreement.

Your treatment may affect other individuals. You should discuss this Agreement with your family, friends, attorney, doctor, minister or any other party you desire before deciding to participate in the Pain Program and indicating that decision by signing this Agreement. You may sign this Agreement only after you have fully discussed the Pain Program and all known risks with you Physician; your signature on this Agreement indicates that you have so discussed the Pain Program, that you have read, fully understand and agree to all of the information and terms of this Agreement.

1. I am Eligible to Participate in the Pain Program

I am in a state of pain in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by my attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area of my body perceived as the source of the pain.

I acknowledge that I have given Physician a complete and accurate medical history and I have been examined by Physician.

Patient’s Initials and Date

I am aware that there are many ways to relieve chronic pain, including electrical stimulation, physical therapy, biofeedback, hypnosis, nerve blocks, mental health therapy, acupuncture and non-opioid drugs. These methods have either been unsuccessfully tried by me or are unacceptable to me as my only form of pain treatment.

I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and that treatment may change throughout my time as a patient at the Pain Clinic. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that Physician will advise me as knowledge and training advances and will make appropriate treatment changes.

I Understand, and Agree to Follow, the Procedures of the Pain Program

I understand that I will be given regular appointments at 16466 Bernardo Center Drive Suite 150 San Diego CA 92128, 4510 Executive Drive Suite 210 San Diego CA. 92121 or 225 E. Second Ave Suite 101, Escondido, CA 92025, (referred to in this Agreement as the "Clinic") which must be kept or rescheduled within three (3) working days. If I fail to arrange another appointment within three (3) working days or reschedule more than two (2) appointments, Physician or the Clinic may terminate me from the Pain Program.

I will take my prescription exactly as prescribed. I fully understand that I should keep a minimum of three (3) days reserve supply of opioids at all times and never exhaust my supply. I will give the Clinic a three (3) working day notice to refill my opioids. There will be no early refills for any reason and I will not call the Physician requesting refills. I fully understand that no prescriptions will be refilled if I lose or destroy any of my medication. Failure to follow the above or take the opioid exactly as prescribed may result in termination of my participation in the Pain Program.

I have selected and will utilize only one pharmacy to fill my prescriptions for opioids. If I change pharmacies, I will inform the Clinic within two (2) working days. I give the Clinic my consent to release my current and future medical records and to discuss my case with all selected pharmacies. My selected pharmacy is listed at the end of this Agreement.

My primary care physician is also listed at the end of this Agreement. I understand that I must maintain a relationship with my primary care physician at all times during my participation in the Pain Program. I will notify Physician within two (2) working days if I change primary care physicians. After I have reached a stable dose, the Clinic may elect to transfer the prescribing of my opioid to my primary care physician.

I agree that the Clinic may attempt to withdraw me from opioids at any time I desire or at Physician's discretion and direction. I understand that withdrawal symptoms may occur. I also agree that the Clinic or Physician may refer me to a drug detoxification center.

I Understand I May Become Addicted and/or Dependent on the Opioid

Patient's Initials and Date

Opioids produce significant side effects and long-term changes in the body in the form of physical dependence and tolerance and may also, but rarely do, cause psychological dependence (commonly referred to as “addiction”).

Physical Dependence

Physical dependence is a pharmacologic property of all opioid drugs. It means that certain typical symptoms will occur if the drug is abruptly discontinued or if an antagonist (a substance which counters opioid effects) is administered.

I understand that I will become physically dependent and if I discontinue the opioids, I will likely suffer withdrawal symptoms which may include, among other symptoms, nausea and vomiting, pain, diarrhea, fever, seizures, flu-like symptoms, chills, headache, loss of appetite, depression and a return of my pain.

Psychological Dependence

Psychological dependence or addiction is a psychological and behavioral syndrome. It is characterized by compulsive drug use, overwhelming interest in securing a supply, and return to drug use after drug detoxification. Addicted persons may exhibit, among other things, drug hoarding, acquisition of drugs from multiple sources, increase drug dosage on their own, and drug sales. There is considerable evidence that addiction is a rare outcome of opioid use by patients who participate in a pain management program supervised by a physician, at least among those with no prior history of drug abuse. However, patients who are administered a high enough dose of an opioid drug for a long enough time may, and probably will, become physically and psychologically dependent. Although addiction is rare, this very unlikely risk of psychological dependence is one that must be acknowledged and accepted by patient and Physician as part of this form of treatment.

I agree to the use of opioids to reduce my pain and suffering, and I fully understand that I may become physically and psychologically dependent upon, or addicted to, the opioids prescribed.

Consent to Drug Screening and Psychological Testing

I agree to provide urine or blood samples for announced or unannounced drug screenings and to submit to physiological evaluations at the request and direction Physician.

Waiver of Privacy Rights Regarding Opioid Usage

I agree to waive, to the extent permitted by applicable law, any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my opioid pain medication and I authorize Physician, other attending doctors, the Clinic, and the pharmacist to cooperate fully, at any time during or after the Pain Program, with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of my pain medication.

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I understand that I may Suffer from Various Side Effects Due to the Opioids

I am aware of the side effects of opioids including, but not limited to: constipation, difficulty with urinary voiding, nausea or vomiting, sedation, drowsiness, confusion, and itching. In addition, reflexes and breathing may be depressed. Most side effects, except constipation, diminish as time goes by because tolerance develops. Control of constipation may be more difficult than control of pain. Bowel maintenance should be taken seriously and treated with a “prophylactic bowel program” recommended by Physician or your attending physician.

I understand there are many other drugs other than opioids (tranquilizers, stimulants, sedatives, or alcohol) which when taken with my opioid may lead to excess drowsiness, intoxication or overdose. I understand that either alone or combined with other drugs, such as alcohol, opioids may impair my ability to safely drive a car, operate machinery, climb stairs, walk, or perform other common activities requiring ordinary coordination and motor skills.

PREGNANCY: If I should become pregnant, I understand that my baby could be born with brain damage, physical problems and/or physical dependence on the opioids and thus experience withdrawal symptoms.

I Understand That I may be terminated from the Pain Program at the Sole Discretion of Physician or the Clinic.

Due to the physically dependent nature of opioids, I agree to only obtain them through the Clinic except in an emergency. If I obtain opioids with the assistance of another clinic or physician, I will inform the Clinic or Physician within twenty-four (24) hours. In this case, the Clinic and Physician reserve the right to terminate me from participation in the Pain Program.

I fully understand that I cannot loan, give or sell my opioids to another person. If I do this, the Clinic or Physician reserve the right to terminate me from participation in the Pain Program.

I understand that if I consume opioids in an amount above that which is prescribed, sell them, give them to someone, or use another mind altering drug not authorized by the Clinic, the Clinic and Physician reserve the right to refuse to prescribe additional opioids, to terminate me from participation in the Pain Program and refer me to an opioid withdrawal program.

I understand that if I fail to comply with any of the provisions in this Agreement the Clinic or Physician reserve the right to refuse to prescribe additional opioids and terminate me from participation in the Pain Program.

I understand that Physician may terminate me from participation in the Pain Program at Physician’s sole discretion using the procedure set forth below.

In the event that Physician or the Clinic decides to terminate me from participation in the Pain Program, I agree that they may provide me, at the discretion Physician or the Clinic, with no more than a thirty (30) day supply of my opioid (this

Patient’s Initials and Date

includes and reserve supply already in my possession, for a total of a thirty (30) day supply). If I have not established a relationship with another pain physician within thirty (30) days of the termination of my relationship with the Clinic, I agree that Physician and the Clinic may cease supplying me with opioids and may refer me to a detoxification or other opioid withdrawal program.

I Understand That I May Terminate My Participation in the Pain Program
I understand that I may leave the Pain Program at any time and seek treatment elsewhere. In this event, the Clinic may prescribe a one (1) week supply of my currently prescribed opioids (this includes any reserve supply already in my possession, for a total of a one week supply). I also understand that I can only return to the Clinic opioid program with a physician's referral and acceptance into the program is at the sole discretion of the Clinic.

Clinic Name:

Pharmacy Name:

Address:

Phone Number:

Primary Care Physician:

Address:

Phone Number:

Psychologist/Psychiatrist:

Address:

Phone Number:

I consent to treatment and agree to comply with all requirements of the Pain Program, including those not specifically stated in the Agreement. All of my questions and concerns regarding treatment and the Pain Program have been adequately answered. If I do not follow the requirements of the Pain Program fully, the Clinic or Physician may discontinue my participation in the Pain Program and may refer me elsewhere for care. A copy of this document has been given to me.

Patient Signature

Date

Please Print Patient Name

Patient's Initials and Date