PAIN MEDICINE PHYSICIANS OF JACKSONVILLE, LLC

Informed Consent and Agreement for Treatment with Opioid Analgesic Medications

Patient Name: ____ Date: ____________

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your pain management specialist to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my pain management specialist undertakes to treat me based on this Agreement.

I have agreed to use opioid analgesics (morphine-like medications) as part of my treatment for acute/chronic pain. I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my pain management specialist is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my pain management specialist or the medication utilization review committee, may result in the termination of our physician/PA/NP-patient relationship. In this case, my provider will stop prescribing these pain- control medicines and will taper off the medication over a period of several days, as necessary, to lessen withdrawal symptoms, Also, a drug-dependence treatment program may be recommended.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my physician before making any changes.

   - I understand that increasing my dose without the close supervision of my pain management specialist could lead to drug overdose, causing severe sedation, respiratory depression and death.
   - I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh," abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to several weeks.

2. I will not request or accept a prescription for opioid pain medicines from any other physician or individual while I am receiving such medication from my pain management specialist. Prescriptions for controlled stimulants or anti-anxiety medicines need to be coordinated with your pain management specialist.

3. I understand the side effects that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, jerkiness, change in personality, sleep changes, potential for increased pain, risks to unborn children, changes in appetite, coordination, sexual desire and performance. Most side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my pain management specialist of any side effects that continue or are severe (such as sedation or confusion). I understand that it may be dangerous for me to operate an automobile or other machinery while using these medication and I may be impaired during all activities, including work. I am also responsible for notifying my pain management specialist immediately if I need to visit another physician or emergency room due to pain.

4. (FOR FEMALE PATIENTS ONLY) I also understand that if I became pregnant, or if I am suspicious that I am pregnant, I will notify the doctor and staff of the office immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold Pain Medicine Physicians of Jacksonville, LLC (PMPJ) its shareholders, officers, directors, employees, contractors and agents harmless for injuries to the embryo/fetus/baby.

5. I understand that the opioid medication is strictly for my own use. I will not share, sell or trade my pain medication with anyone. If children are in the house, a childproof top is mandatory.

6. I understand I must contact my pain management specialist before taking benzodiazepines (drugs like Valium, Xanax or Ativan), sedatives (drugs like Soma or Fiorinal) and antihistamines (drugs like Benadryl).

Informed Consent and Agreement for Treatment with Opioid Analgesic Medications (cont.)

I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I cannot consume alcohol or use recreational/illegal drugs (including marijuana, cocaine, heroin, etc.) while on opioid analgesic medications. If consumed, the consequence will be termination from the program. I understand that opioid prescriptions will not be mailed. During the time that my dose is being adjusted, I will be expected to return to the Pain Medicine Physicians of Jacksonville, LLC no less frequently than one time a month. After I have been placed on a stable dose, I will return to the Pain Medicine Physicians of Jacksonville, LLC whenever instructed by my pain management specialist.

7. I am responsible for my opioid prescriptions. I understand that refill prescriptions:

   - Can only be written for a one-month supply and will be filled at the same pharmacy (as designated below). I will update my record of pharmacy should it change.

     Pharmacy name: ____ Phone #: (_____)_____________

     Pharmacy Address: ____zip: ______________

   - Shall be made during regular office hours 8:30 AM - 5 PM Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays or on weekends. Prescriptions will not be mailed.
   - Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication.
   - I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
   - I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. Lost or stolen medicines will likely not be replaced.
   - Shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least one week ahead to schedule pick-up for my prescriptions.

8. While physical dependence is to be expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification. I agree, if this is the case, that I may need to be admitted for detoxification to appropriate facility

   - Physical dependence is common to many drugs, such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.
   - Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping." when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged from Pain Medicine Physicians of Jacksonville, LLC.
   - Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

9. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the pain management specialist that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the pain management specialist.

10. I agree to submit to urine, saliva and/or blood screens at any time as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the pain management specialist to inspect.

11. I further understand that if I do not follow any of the above conditions or provisions, I may (at my physician's discretion) no longer receive any type of opioid medication.

    - Controlled medication therapy may be discontinued if patients: (i) develop tolerance which cannot be managed; or (ii) have side effects, which cannot be controlled.
    - Discharge from Pain Medicine Physicians of Jacksonville, LLC will occur if: (i) patients become addictive or abusive of other medications and substances (this includes alcohol), (ii) increase their medications without prior approval from my pain management specialist, (iii) obtain non-authorized controlled medications from other practitioners; (iv) fill prescriptions at multiple pharmacies; (v) sell, give away or otherwise divert the medications from their intended use; alter prescriptions; or (vi) other serious concerns arise. Pain Medicine Physicians of Jacksonville, LLC always cooperates with authorities if illegal activities occur.

12. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the pain management specialist that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the pain management specialist.
13. I agree to submit to urine, saliva and/or blood screens at any time as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the pain management specialist to inspect.

14. I further understand that if I do not follow any of the above conditions or provisions, I may (at my physician's discretion) no longer receive any type of opioid medication.

15. I also understand that if I have a problem or question with any of the terms of this Agreement, I must make an appointment to discuss this with the pain management specialist and receive clarification before a problem or crisis situation arises.

16. I authorize the release of any information and medical records by the pain management specialist, his or her designee, and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the pain management specialist, his or her designee, and my pharmacy to contact any legal authority, or regulatory agency to obtain or provide information about my care or actions if the pain management specialist feels it is necessary and to cooperate fully with any city, state or federal law enforcement agency, including the Florida Board of Pharmacy and Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my pain management specialist to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

17. I understand that no agreement can anticipate all events in medical treatment which may arise and that me and my heirs, will hold harmless Pain Medicine Physicians of Jacksonville, LLC , its shareholders, officers, directors, employees, contractors and agents for all resultant problems. This Agreement supersedes and replaces all previous agreements.

By signing below, I certify that I have read the above Information, I have received a copy of the contract and all my questions regarding the treatment of pain with opioid analgesic medications have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient signature: ____ Date: ___________

Physician: ____ Date: ____________