INFORMED CONSENT AND PAIN MEDICINE AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

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NAME OF PATIENT: _____ DATE: _____

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 about whether or not to take the drug(s) knowing the benefits, 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 safety and compliance. For 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.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition of chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. I hereby authorize and give my voluntary consent for my physician to administer or write a prescription(s) for dangerous and/or controlled drugs (medications) as a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with my Pain Medicine Physician the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief, improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. 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 accidental overdose, injury and death are also possibilities as a result of taking these medication(s).

I understand that concurrently consuming sedating substances like alcohol or taking additional types of sedating controlled medications such as benzodiazepines and gabapentenoids along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation, it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical specialists   to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATELY 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). 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 AND EXAMINATIONS BEFORE AND DURING MY TREATMENT. Those tests include random unannounced checks for drugs (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests, and my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from my Pain Medicine Physician's care.

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 heartbeat), 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, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to using heavy equipment or a motor vehicle, working in unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still want 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 to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for a complete cure, but the goal of taking medication(s) regularly is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment may 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 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 benefits. I have been given the opportunity to ask questions about my condition, treatment, risks of non-treatment, drug therapy, 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.

For female patients only:

_____To the best of my knowledge I am NOT pregnant.

_____If I am not pregnant, I will take appropriate precautions to avoid pregnancy during my course of treatment. I accept that it is my responsibility to inform my physician immediately if I become pregnant. _____If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) to ensure complete safety of my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo, fetus, or baby.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

This pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are many strict 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.

The term “Pain Medicine Physician” below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician’s Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

My Pain Medicine Physician may at any time choose to discontinue 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.

(Patient Shall Acknowledge All Provisions by Initialing)

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.

_____ I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and/or controlled substances for the treatment of chronic pain. NOTE: Prescription THC is not marijuana, but it does show up on urine drug tests, therefore I will inform my provider if I have been prescribed the FDA-approved synthetic THC compounds such as nabilone and/or dronabinol which are available for managing chemotherapy-induced nausea and vomiting, as well as for stimulating appetite in cases of AIDS-related anorexia in patients.

_____ I will not use any Low-THC cannabis unless my Pain Medicine Physician also gives me written permission to use the Low-THC cannabis (as defined in the Texas Occupations Code) that has been prescribed by a registered Texas compassionate-use physician.

_____I agree to submit to laboratory tests for drug levels upon request, including urine and/or blood or saliva screens, to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for alcohol or illegal substance(s), 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 specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I am traveling, and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) before the time of my next scheduled refill, even if my prescription(s) run out. My Pain Medicine Physician may limit the number and frequency of prescription refills.

_____ I understand that my medication(s) will be refilled regularly. 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. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation, may issue an early refill.

_____ My Pain Medicine Physician will manage all of my chronic pain symptoms. Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatment of chronic pain. I will receive controlled substance medication(s) only from ONE Pain Medicine Physician unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health-related issues must be managed by my primary care physician and my other specialists.

_____I agree that I will inform any physician who may treat me for any other medical problem(s) that I am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.

_____I hereby give my Pain Medicine Physician permission to discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my Pain Medicine Physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____ I will use the medication(s) exactly as directed by my Pain Medicine Physician. Any unauthorized increase in the dose of medication(s) may cause the discontinuation of my pain treatment(s).

_____ If anyone other than my Pain Medicine Physician prescribes me medication(s) to treat acute, postsurgical or chronic pain, then I will disclose this information to my Pain Medicine Physician at or before my next date of service, which must include, at a minimum, the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

____I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which are designed to reverse the effects of an accidental or intentional overdose of pain medication.

_____ All medication(s) must be obtained at one pharmacy designated by me, with the exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my Pain Medicine Physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my Pain Medicine Physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the medication(s) may be discontinued.

_____ I must keep all follow-up appointments as recommended by my Pain Medicine Physician or my treatment may be discontinued.

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

_____ I will not use any cannabidiol (CBD) products unless one of my physicians has prescribed me Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the use of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.

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

_____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) 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 medicine program recommended by my Pain Medicine Physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and I will discontinue it before starting these medications. I certify and agree to the following

_____ I will inform Dr Moran and/or his staff of all controlled substances and other medications I am taking at each visit, and it is my responsibility to accurately update Dr. Moran and/or his staff of any medicines I am taking

_____I understand naroctics can be addictive and Dr. Moran always tries to minimize use of narcotics per national guidelines for as short duration as possible, as in weeks. If Dr. Moran gives me narcotics for longer periods, he is doing so wit m full consent and I release Dr Moran from any consequences I may have due to my choice to continue narcotics for long term use. I understand I am going against Dr. Morans medical advice if I continue narcotics per my preferences instead of as recommended by Dr. Moran and/or his staff.

_____I understand Dr. Moran can wean my narcotics based on his clinical decision, even in the interval between visits and without notification. Dr. Moran will try to inform me of any changes, but may not be able to inform me before I pick up my prescription. I am also aware it is my responsibility to verify each prescription I obtain as to medicine, dose, quantity and directions for taking as changes could be made without my knowledge. If I pay for a prescription without verifying all information and directions, I will be responsible for any consequence of obtaining any prescription that differs from my previous prescriptions.

_____I am aware of Dr Moran's medicine management policy. If no other therapies or options have been tried and completed after 12 months of only narcotic management and/or patients have not tried or completed other options for pain relief, Dr. Moran can wean my narcotics as he does not only do narcotic medication management unless he decides to based on his clinical expertise

_____ I am aware Dr Moran frequently has high school, college, and/ or pre med students following him and give consent to have them involved in my visits and/or interventions. If I don't consent to allowing students in the room with my visits/ interventions, I will notify Dr. Moran and no students will be allowed in my visits/ interventions.

(Patient shall acknowledge Educational and Marketing Consent by Initialing):

_____ I consent to receiving educational and/or marketing material from Dr. Moran and/or his associations including emails, texts, and social media notifications. If I do not consent to receiving these educational and marketing materials, I will notify Dr Moran immediately.

(Patient Shall Acknowledge All Provisions by Initialing):

_____ 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 painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).

_____ 3) No guarantee or assurance has been made to me 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.

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this Pain Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

_____ Name and contact information for pharmacy

_____

___ Patient Printed Name Physician Printed Name (or Appropriately Authorized Assistant)

_____ Patient Signature

Physician Signature (or Appropriately Authorized Assistant)