INFORMED CONSENT AND
PAIN MANAGEMENT AGREEMENT

This form is used by HPM to help create a clear understanding of the rules and expectations that are involved if it is
decided that opioid medication(s) (narcotics) may be indicated as part of your treatment.

If you do not want to include narcotics as a component of your treatment, you do not need to fill this out.

NAME OF PATIENT: ________________________________________________  DATE: __________________

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management policy and agreement relate to my use of opioids, also called ‘narcotics’, ‘pain killers’, and
other prescription medication(s) for chronic pain prescribed by my Huntsville Pain Management (HPM) provider. 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 this agreement. My 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 may result in my discharge from care and treatment.
Discharge may be immediate for any illegal 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 _______ Initials
- I will disclose to HPM all medication(s) that I take at any time, prescribed by any other care provider. _______ Initials
- I will use the medication(s) exactly as directed by HPM. _______ Initials
- I agree not to share, sell or otherwise permit others, including my family and/or friends, to have access to
  these medications. _______ Initials
- I will not allow or assist in the misuse/diversion of my medication(s), nor will I give or sell them to
  anyone else. _______ Initials
- All medication(s) must be obtained at a single agreed-to pharmacy. Should the need arise to change pharmacies, my
  physician must be informed at the next scheduled visit. I will use only one pharmacy and will provide my pharmacist
  a copy of this agreement. I authorize my HPM provider to release my medical records to my pharmacist as
  necessary. _______ Initials
- I understand that my medication(s) may be refilled on a regular basis. 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. _______ Initials
- Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) may be 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)
  prior to the time of my next scheduled refill, even if my prescription(s) run out. _______ Initials
- I will receive controlled medication(s) only from HPM unless it is for an emergency or the medication(s) that is/are being
  prescribed by another physician is approved my HPM. Information that I have been receiving medication(s) prescribed by other
  doctors that has not been approved by HPM may lead to a discontinuation of medication(s) and treatment. _______ Initials
If it appears that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then HPM may try alternative medication(s) or may taper me off all medication(s). I will not hold HPM liable for any problems caused by the discontinuance of medication(s). 

I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substances(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 practitioner, such as an addictionologist or a physician who specializes 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, 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 my HPM physician to achieve increased function and improved quality of life.

I agree that I shall inform any doctor or provider 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 HPM permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s).

I must take the medication(s) as instructed by HPM. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

Refills will be made only during scheduled appointments. Refills will not be made over the phone, at night, or on weekends. This policy will be strictly adhered to.

Refills will not be made if I “run out early” or “lose a prescription” or “spill or misplace” my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. (Treat your medication like a valuable piece of jewelry). If medications are stolen and a police report regarding the theft is completed, an exception may be made at the discretion of your provider.

I agree that I will submit a random urine test, approximately twice per year and when requested by my provider to determine my compliance with and my metabolization of pain control medication(s). Tests will also include screens for illegal substances. If I am unable to provide a urine sample, I agree to submit to saliva testing.

I understand that I am a patient of Huntsville Pain Management and that I am not guaranteed to see any specific provider. For the ease of scheduling, and to meet insurance contracts, I agree to see any of the HPM providers.