MISSION
advanced pain management & spine center

PAIN MANAGEMENT PROGRAM PARTICIPATION AGREEMENT AND CONSENT

This Agreement is between _____ and Mission Advanced Pain Management & Spine Center, P.C. The purpose of this agreement is to outline policies regarding controlled substances medications, referred below as "Opioids".

Different Pain Conditions might need to be effectively managed through the use of controlled substances medications. The long-term use of Opioid medications (narcotic analgesics or scheduled medications) is somewhat controversial because of the uncertainty regarding the extent to which this treatment actually improves the patient's quality of life.

There are potential risks for Opioid administration, the extent of these risks is not certain. Because these drugs all have potential for abuse or diversion, rather strict accountability is necessary when these medications are prescribed. However, even when being administered by an experienced and competent physician, opioids may have lots of side effects, misused and abused and may result in physical dependence or addiction. Opioids are closely monitored and controlled by local, state and federal governments and may be prescribed or administered only under strict guidelines and as a last resort after exhausting all other possible interventional/medical approaches to safely control the condition.

You must carefully read this 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 the Agreement.

Your treatment may affect other individuals. You should discuss the 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 your 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.

The goal of treatment is to reduce pain to a tolerable level that allows increased function. Daily use of opioids is associated with certain risks; the risks include but are not limited to:

- *Addiction*
- *Withdrawal symptoms*
- *Allergic reactions, overdose and/or fatal complications*
- *Breathing problems*
- *Cardiac problems, up to increased risks of Heart Attacks*
- *Impotence, Impaired Sexual function, desire and hormonal imbalance*
- *Drowsiness, Dizziness and/or Confusion*
- *Impaired judgment and inability to operate machines or drive motor vehicles*
- *Nausea, vomiting and/or constipation*
- *Development of tolerance*
- *<u>PREGNANCY:</u> 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 agree to the following guidelines:

1. ___I will take this medication only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. Unauthorized changes may result in serious side effects and my running out of medications early. Early refills will not be allowed and will be considered a violation to this agreement.

2. ___I will obtain all opioids from one physician or, during his or her absence, by the covering physician. Requests for pain medications from the On-Call physician (nights and weekends) will not be honored. Opioids renewal or refills cannot be called to a pharmacy.

3. ___If I obtain opioids with the assistance of another clinic or physician, even in case of Emergency, I will inform the Clinic or Physician within twenty four (24) hours.

4. ___I will obtain all scheduled medications from one pharmacy. I must notify the Pain Clinic if I change pharmacies. The contact information of the pharmacy that I have selected is as listed at the last page of this agreement.

5. ___The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the pharmacists at the dispensing pharmacy for purposes of maintaining accountability.

6. ___I will submit to random pill counts, urine and/or serum toxicology screens as requested to monitor my compliance. Presence of unauthorized substances may prompt referral for assessment of addiction and discontinuation of further Opioid prescriptions.

7. ___I understand that despite the fact that Alcohol and Medical Marijuana usages are considered legal in the state of California, Dr Beshai will not be able to prescribe any opioid or controlled substances medications that might have life threatening interactions with those substances.

8. ___I understand that I am subject to referral for psychological evaluations at the request and discretion of Physician. Marijuana is considered a recreational drug by the DEA and Dr. Beshai does not prescribe Controlled Substances to patients using recreational drugs.

9. ___I will not share, sell or otherwise permit others to have access to these medications.

10.___Medications will not be replaced if they are lost or stolen. It is expected that I will obtain a safe for my medications and guard against theft.

11.___I understand that prescriptions may be issued early, for example, if the treating physician is going to be out of town, or if I am going to be out of town when a refill is due. However, I also understand and accept that these prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

12.___If legal authorities have questions concerning my treatment (as might occur, for example, if there was a concern that I was obtaining medications at several pharmacies), I hereby waive all confidentiality, including my patient-physician privilege and I consent to giving the authorities full access to my Mission Advanced Pain Management & Spine Center Records of opioid administration.

13.___ I understand that failure to complete the treatment plan as outlined by my pain management physician including consultations to other services and physicians, lab tests, or radiographic studies, will be considered Non-Compliance to this agreement and might result in termination of Doctor-Patient relationship.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL RESULT IN PERMANENT CESSATION OF OPIOID PRESCRIBING BY THIS PHYSICIAN AND MAY RESULT IN MY COMPLETE DISMISSAL FROM THE ENTIRE PRACTICE. 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'S NAME

PATIENT'S SIGNATURE

DATE

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

California Prescription Drug Monitoring Program-Information on PMP

I authorize **Mission Advanced Pain Management & Spine Center to request and receive from the California Prescription Drug Monitoring Program any and all records held relating to Schedule II-V controlled substances dispensed to the patient named below**. I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoke, this consent will expire one year after the date of my signature unless otherwise specified.

PATIENT'S NAME

PATIENT'S SIGNATURE

DATE

Pharmacy Name :

Address :

Phone Number :

Primary Care Physician:

Address :

Phone Number :

Psychologist/Psychiatrist:

Address :

Phone Number :

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