

 **8817 E. Mission Ave., Ste 106, Spokane Valley, WA 99212**



**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 health care provider, 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 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 provider (referred to below as your “Provider”), 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 specially 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 indication 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 Provider; 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.

**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 pain.

I acknowledge that I have given Provider a complete and accurate medical history and I have been examined by Provider. 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-opioids 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 opioids 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 unknown risks associated with the ling-term use of controlled substances and that the Provider 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 Integrative Health & Healing (referred to in this Agreement as the “IHH”) 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, Provider or the Pain Clinic may terminate me from the Pain
Program.

I will take 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 IHH a three (3) working days 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 opioids 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. I f I change pharmacies; I will inform IHH within two (2) working days. I give IHH my consent to release my current and future medical records and to discuss my case with all 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 Provider within two (2) working days if I change primary care physicians. After I have reached a stable dose, IHH may elect to transfer the prescribing of my opioids to my primary care physician.

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

**I Understand I May Become Addicted and/or Dependent on the Opioid**
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 opioids drugs. It means that certain typical symptoms will occur if the drug is abruptly discontinued or if an antagonist (a substance which counters opioids 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 the 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, and acquisition of drugs from multiple sources, increasing 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 lesson 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 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 am subject to psychological evaluations at the request and discretion of the Provider.

**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 the Provider, other attending doctors, the Provider Assistant, IHH 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.

I authorize Provider, other attending doctors, the Provider Assistant, IHH, and the pharmacist to review and discuss with my immediate family members (including spouse, children, or identified caretakers) my participation in the Pain Program, including but not limited to, opioids and treatments I am receiving as part of the Pain Program.

**I Understand That I May Suffer From Various Side Effects Due To the Opioid**
I am aware of the side effects of opioids including, but not limited to: constipation, difficulty with urinary voiding, nausea or vomiting, sedations, drowsiness, confusion, and itching. In addition, reflexes and breathing may be depressed. Most side effects, except constipation, diminish with time because tolerance develops. Control of constipation may be more difficult than the control of pain. Bowel maintenance should be taken seriously and treated with a “prophylactic bowel program” recommended by Provider or my attending physician.

I understand there are many other drugs other than opioids (tranquilizers, stimulants, sedatives, or alcohol) which when taken with my opioids 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 Provider Or IHH.
Due to the physically dependent nature of opioids, I agree to only obtain them through IHH except in an emergency. If I obtain opioids with the assistance of another clinic or physician, I will inform IHH or Provider within twenty four (24) hours. In this case, IHH and Provider 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, IHH or Provider reserves the right to terminate me from participation in the Pain Program and report me to the proper law enforcement agency.

I will not take more opioid medications than prescribed or attend IHH in an over-medicated state. If I do, I understand that Provider and IHH 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 drugs not authorized by IHH and Provider reserve the right to refuse to prescribe additional opioids and to terminate me from participation in the Pain Program.

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

I understand that Provider or IHH decides to terminate me from participation in the Pain Program, I agree that they may provide me, at the discretion of Provider of IHH, with no more than a thirty (30) day supply of my opioid (this includes any 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 IHH, I agree that Provider and IHH 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 Prescription In The Pain Program**.
I understand that I may leave the Pain Program at any time and seek treatment elsewhere. In this event, IHH may prescribe a one (1) week supply of my currently prescribed opioid (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 IHH opioid program with a physician’s referral and acceptance into the program is at the sole discretion of the Clinic.

I understand that if I drive I may be arrested for DUI (influence of medication)
I understand that I need to take the prescription exactly as prescribed. If I take more than the prescribed amount I understand I that if I drive I may be arrested for DUI (influence of medication)

Clinic Name: Integrative Health & Healing

Pharmacy Name & Phone Number:

Primary Care Physician:

Phone Number:

Psychologist/Psychiatrist:

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, IHH or Provider 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.

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Patient Signature Date

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Provider Signature Date

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Medication Refill Policy

Medication refills require a monthly appointment with your provider.

There are no medication refills on Friday afternoons or on the weekends.

IHH will not tolerate early refills due to any circumstance.

It is the patient’s responsibility to notify the office in advance for medication refills.

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Patient Signature Date

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