Florida Medical Pain Management, LLC

☐ **6333 54th Avenue North**
St. Petersburg, Florida 33709
Ph: (727)548-6100
Fax: (727)545-0960

☐ **8115 State Rt. 54**
New Port Richey, Florida 34655
Ph: (727)376-6111
Fax: (727)376-6199

☐ **5270 Apple Gate Drive**
Spring Hill, Florida 34606
Ph: (352)340-5990
Fax: (352)340-5991

PAIN MANAGEMENT AGREEMENT

Our goal in the field of Pain Management Medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. I strive to manage pain through means other than medications to allow patients to live a relatively pain free life. I seek to treat the cause of the pain and not the symptoms. **However, I also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this Agreement is to clarify the conditions under which Florida Medical Pain Management's Physicians will prescribe medications for you. This agreement will help you and the Physician comply with the laws regarding controlled pharmaceuticals and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each and every item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS AND CONDITIONS IN CONNECTION WITH MY TREATMENT AND PARTICIPATION IN THE PAIN PROGRAM AND AS A CONDITION TO RECEIVING PAIN MEDICATION:

1. I WILL USE MY MEDICATION(S) AT A RATE NO GREATER THAN THAT PRESCRIBED BY THE PHYSICIAN. IF I DO OVER-USE MY MEDICATION, THAT MEDICATION WILL NOT BE REFILLED EARLY, AND I MAY BE WITHOUT PAIN MEDICATION FOR SOME PERIOD OF TIME.

2. I WILL NOT SHARE, SELL, OR TRADE MY MEDICATION WITH ANYONE. I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICINES, INCLUDING OPIOID PAIN MEDICINES, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICINES FROM ANY OTHER DOCTOR. I WILL SAFEGUARD MY WRITTEN PRESCRIPTIONS AND PAIN MEDICINE FROM LOSS OR THEFT. I UNDERSTAND THAT LOST OR STOLEN WRITTEN PRESCRIPTIONS OR MEDICINES WILL NOT BE REPLACED.

3. SUDDEN DISCONTINUATION OF A NARCOTIC PAIN MEDICATION MAY LEAD TO UNPLEASANT OR DANGEROUS WITHDRAWAL SYMPTOMS.

4. THE POTENTIAL RISKS AND SIDE EFFECTS OF MEDICATIONS TAKEN FOR PAIN EITHER SHORT TERM OR LONG TERM CAN INCLUDE: DROWSINESS, NAUSEA, CONSTIPATION, ITCHING, DIFFICULTY WITH URINATION, TOLERANCE, DEPENDENCE, ADDICTION, AND OVERDOSE.

5. IN THE EVENT THAT THE PHYSICIAN FEELS THAT MY DOSE OF PAIN MEDICATION IS EXCESSIVE OR MAKES THE DIAGNOSIS OF ADDICTION OR OVERDOSE, HE/SHE WILL REDUCE THE MEDICINE OVER A PERIOD TIME (DAYS, WEEKS, MONTHS) AS NECESSARY TO AVOID WITHDRAWAL SYMPTOMS. ALSO, A DRUG-DEPENDENCE TREATMENT OR DETOXIFICATION PROGRAM MAY BE RECOMMENDED.

6. I UNDERSTAND AND AGREE THAT I AM NOT TO RECEIVE ANY TYPE OF PRESCRIPTION PAIN OR SEDATIVE MEDICATION FROM ANY OTHER PHYSICIAN UNLESS THERE IS A SPECIFIC MEDICAL NECESSITY. SHOULD MY CAREGIVER OR I RECEIVE ANY PAIN OR SEDATIVE MEDICATIONS FROM ANY OTHER PHYSICIAN, MY CAREGIVER OR I MUST INFORM FLORIDA MEDICAL PAN MANAGEMENT EITHER BY TELEPHONE OR IN WRITING WITHIN 72 HOURS OF HAVING FILLED THE PRESCRIPTIONS.

7. REFILLS OF MY PRESCRIPTIONS WILL BE ISSUED ONLY AT THE TIME OF AN OFFICE VISIT, DURING REGULAR OFFICE HOURS, OR IMMEDIATELY FOLLOWING A PROCEDURE.

8. REFILLS **<u>WILL NOT</u>** BE AVAILABLE DURING EVENINGS, ON WEEKENDS OR HOLIDAYS, AND WITHOUT **<u>AT LEAST 48 HOURS NOTICE</u>** TO THE PHYSICIAN OR HIS OFFICE STAFF.

9. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY SUPPLY OF PAIN MEDICATION AND TO MAKE TIMELY APPOINTMENTS WITH MY PHYSICIAN TO HAVE MY PRESCRIPTION(S) REFILLED. **LAST-MINUTE REQUESTS FOR PRESCRIPTION REFILLS ARE NOT WELCOME.**

10. MY PHYSICIAN MAY, AT HIS DISCRETION, ISSUE A REFILL OF MY MEDICATION (S) BASED ON A TELEPHONE CONVERSATION THAT WE HAVE REGARDING MY PAIN CONDITION AND THE EFFECTS THAT PRESCRIBED MEDICATIONS HAVE ON THIS CONDITION.

11. I WILL COMMUNICATE FULLY AND TRUTHFULLY WITH MY PHYSICIAN ABOUT THE CHARACTER AND INTENSITY OF MY PAIN, THE EFFECT OF THE PAIN ON MY DAILY LIFE, AND HOW WELL THE MEDICINE IS HELPING TO RELIEVE THE PAIN. I UNDERSTAND THAT I, OR MY CAREGIVER IS RESPONSIBLE FOR INFORMING THE PHYSICIAN EITHER IN PERSON, AT FOLLOW-UP, OR BY TELEPHONE AT THE PAIN CENTER TELEPHONE NUMBER (727-548-6100) DURING REGULAR BUSINESS HOURS (9:00 A.M. TO 4:30 P.M., MONDAY THROUGH FRIDAY) REGARDING ANY PROBLEMS OR SIDE EFFECTS ENCOUNTERED WITH THE MEDICATION.

12. I HAVE BEEN ADVISED TO ABSTAIN FROM OR SIGNIFICANTLY MODERATE MY USE OF ALCOHOLIC BEVERAGES WHILE TAKING THIS MEDICATION FOR MY PAIN CONDITION. I WILL NOT USE ANY ILLEGAL CONTROLLED SUBSTANCES, INCLUDING MARIJUANA, COCAINE, HEROIN, ECSTASY, ETC. IF I SMOKE CIGARETTES, I UNDERSTAND THAT I WILL BE ASKED TO QUIT. CIGARETTE SMOKERS TYPICALLY HAVE A DECREASED RESPONSE TO PAIN TREATMENT BECAUSE OF THE EFFECTS OF SMOKING ON OXYGEN DELIVERY TO THE PERIPHERAL TISSUES. THE PAIN CENTER WILL DO WHAT IT CAN TO ASSIST YOU IN SMOKING CESSATION. ADDITIONALLY, OBESITY IS ONE OF THE MOST IMPORTANT CAUSES OF FAILED TREATMENT FOR CHRONIC PAIN. EVERY TEN POUNDS OF EXCESS WEIGHT THAT ONE CARRIES ON HIS/HER BODY RESULTS IN ONE HUNDRED POUNDS OF INCREASED PRESSURE ON THE SPINE, VERTEBRAL DISCS, AND SPINAL NERVES. EXCESSIVE WEIGHT WILL THEREFORE RESULT IN AN INCREASE IN PAIN. IF YOU ARE OVERWEIGHT YOU WILL NEED TO ENROLL IN A WEIGHT LOSS PROGRAM. THE PAIN CENTER WILL ASSIST YOU IN DIETARY MEASURES TO HELP YOU LOSE WEIGHT, AND PHYSICAL THERAPY WILL ALSO BE DIRECTED IN THIS AREA AS WELL.

13. IF PHYSICAL THERAPY IS PRESCRIBED, I AGREE TO ATTEND AND PARTICIPATE TO THE FULLEST EXTENT POSSIBLE. IF THERE ARE ANY PROBLEMS WITH MY PHYSICAL THERAPY, I AGREE TO COMMUNICATE THIS TO MY PHYSICIAN SO THAT HE CAN MAKE THE APPROPRIATE CHANGES IN MY THERAPY PROGRAM.

14. I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY MY PHYSICIAN TO DETERMINE MY COMPLIANCE WITH MY REGIMEN OF PAIN MEDICATION. FURTHERMORE, AT MY PHYSICIAN'S DISCRETION, THE PRIMARY CAREGIVER WHOSE SIGNATURE APPEARS BELOW SHALL ALSO BE SUBJECT TO PERIODIC URINE AND/OR BLOOD TESTING.

15. IF REQUESTED, I WILL BRING ALL UNUSED PAIN MEDICINE TO AN OFFICE VISIT FOR A "PILL COUNT." MY PHYSICIAN MAY REQUEST ADDITIONAL "PILL COUNTS" AT ANY TIME, AND I AGREE TO COMPLY WITH THESE REQUESTS. I AGREE THAT I OR MY CAREGIVER WILL BRING THE MOST RECENT PRESCRIPTION CONTAINER FOR EACH MEDICATION TO EACH VISIT WITH MY PHYSICIAN. THESE CONTAINERS MUST CORRESPOND TO THEIR LAST PRESCRIPTION RECORDED IN THE MEDICAL RECORD WITH THE PRESCRIPTION LABELS INTACT AND LEGIBLE SO THAT THE PHYSICIAN IN THE MEDICAL RECORD MAY DOCUMENT APPROPRIATE CONTROL INFORMATION.

SPECIFICALLY, THE PRESCRIPTION REGISTRATION NUMBER AND PHARMACY TELEPHONE NUMBER WILL BE NOTED AND VERIFIED.

16. I WILL USE ONLY ONE PHARMACY TO FILL PRESCRIPTIONS FOR MY PAIN MEDICATIONS. I AUTHORIZE MY PHYSICAIN AND MY PHARMACY TO COOPERATE FULLY WITH ANY CITY, STATE OR FEDERAL LAW ENFORCEMENT AGENCY, INCLUDING THIS STATE'S BOARD OF PHARMACY, IN THE INVESTIGATION OF ANY POSSIBLE MISUSE, SALE OR OTHER DIVERSION OF MY PAIN MEDICINE. I AUTHORIZE MY DOCTOR 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. I FURTHER CONSENT TO MY PAIN MANAGEMENT PHYSICIAN CONTACTING OTHER PHYSICIANS AND/OR OBTAINING THE RESULTS OF DIAGNOSTIC TESTING (PAST OR PRESENT) IN ORDER TO OBTAIN ADEQUATE INFORMATION ABOUT MY CONDITION.

17. I UNDERSTAND THAT FURTHER PRESCRIPTIONS ARE SOLELY AT THE DISCRETION OF MY PAIN MANAGEMEMENT PHYSICIAN.

18. I FURTHER UNDERSTAND THAT THIS AGREEMENT IS ESSENTIAL TO THE TRUST AND CONFIDENCE NECESSARY IN A DOCTOR-PATIENT RELATIONSHIP AND THAT MY PAIN MANAGEMENT PHYSICAIN UNDERTAKES TO TREAT ME BASED ON THIS AGREEMENT. I UNDERSTAND THAT IF I BREAK THIS AGREEMENT OR PROVIDE ANY FALSE INFORMATION, MY FLORIDA MEDICAL PAIN MANAGEMENT PHYSCIAN WILL STOP PRESCRIBING THESE PAIN-CONTROL MEDICINES AND I MAY BE IMMEDIATELY REMOVED FROM THE CLINIC.

I agree to follow all of the guidelines that are described above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request. I voluntarily consent to participation in the pain medication program described in this Agreement.

Patient signature: ____ Date: ________________________________