GRANITE STATE PAIN ASSOCIATES

GRANITE STATE SURGICENTER

www.PainMD.com

Informed Consent and Treatment Agreement

Name _____ **Date of Birth:**_____

Please Initial All Items:

1. The Pain Management providers at GSPA/GSSC will provide treatment and medications related to pain. I should consult my primary care provider for other non-pain-related medical issues. If medications for pain are prescribed by my PCP, dentist, ER doctor, or others, I will contact my GSPA/GSSC provider for permission BEFORE I fill the prescription or consume the medication. If the medication is administered in a true emergency situation, I will notify my GSPS/GSSA provider as soon as possible. If I fail to inform GSPA/GSSC, I may be discharged from the practice.
2. I understand that there are risks involved with narcotic pain relievers. The risks include but are not limited to: constipation, sedation, altered appetite, allergic reactions, and problems with coordination, sexual dysfunction, lowered testosterone, personality changes, bowel obstruction, respiratory depression, and birth defects/infant withdrawal at birth. Chronic use of opioid analgesics often results in tolerance (requiring more medication) and habituation (physical dependence on the medication). If my medication is stopped suddenly or the dose decreased rapidly, I may experience withdrawal. Use of this medication may also result in psychological addiction and in hyperalgesia (increased pain perception).
3. I understand that opioids are NOT recommended for use during pregnancy due to the potential for harm to the infant. Babies born to women taking opioids often suffer withdrawal after birth and require prolonged medical care in a specialized nursery unit. GSPA/GSSC providers urge all women of childbearing age who are taking opioids for pain and are not using a form of dependable birth control, to discuss with their OB/GYN or primary care provider what methods might be appropriate for them. I also recognize that my GSPA/GSSC provider will make decisions regarding my care based on what is best for the fetus in the event that I become pregnant. This decision may include decreasing, discontinuing, or changing my opioid to a potentially less harmful medication. I understand there is some risk of miscarriage with all of these options.
4. I will take my medications only as my Pain Management provider prescribes them and I understand my provider must PRE-approve any adjustments. I understand my provider may not prescribe additional pain medications should I run out ahead of schedule. He/She might, if indicated, prescribe alternative medications to ease the effects of withdrawal. **I understand not taking my prescriptions as directed could cause the Pain Management provider to discharge me from the practice.**
5. I understand that the Pain Management providers will generally not be available to prescribe medication during evenings, weekends, or after 12 noon on Fridays. It is my responsibility to call my provider at least **3(three) *business* days** in advance of running out of medications.
6. I understand that the Pain Management provider is not obligated to seek prior authorization (PA) of medication (or medication doses) not covered by my insurance.
7. I understand that I must call **at least 24 hours** prior to any appointment if I need to cancel. If I do not come for my appointment or I fail to provide sufficient notice, I am subject to a 'no show' cash fee.
8. I understand that I must provide a **viable contact number** at all times or my provider may not prescribe medications.
9. I understand that my pain medications are generally not to be adjusted over the phone. I must make an appointment to be seen in person.
10. I understand that if I am having intolerable side effects to my pain medications that I stop the medication and immediately contact my Pain Management provider to let him/her know.
11. I understand that my pain is my own pain, not my families' or spouse's. Therefore, I need to be the person to communicate with the Pain Management provider and his/her staff if at all possible.
12. I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments.
13. I will inform my Pain Management provider of any changes in any other medications I am receiving, including holistic/herbals, from other physicians or practitioners.
14. I understand that combining illegal substances with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I do so, I may be discharged from the practice or be asked to seek treatment at a drug rehab facility.
15. If I feel tired or mentally foggy in response to meds, **I will not drive, operate heavy equipment**, or serve in any capacity that might endanger me or the public. I understand that this is most likely to occur during dosage adjustments and when starting new medications.

16. I will submit my own urine specimen for drug screen (narcotic, cannabis, cocaine, amphetamine, PCP, alcohol, benzodiazepine, and others) upon my provider's request as often as directed. My Pain Management provider may ask that a clinical staff member observe me providing the appropriate specimen. If my drug screen indicates the presence of illegal or otherwise inappropriate substances, I may be discharged or required to seek treatment at a drug rehab facility.
17. I understand that I will be required at any time with short notice to bring in my medication for inspection and counting. If I do not show or have the appropriate amount of medication, I may be discharged. I may never dispose of medication myself without a staff member as a witness
18. I allow my Pain Management provider to communicate with other providers regarding my medical care, consistent with HIPAA guidelines.
19. I will not sell, share, or trade my medication with anyone.
20. I will safeguard my written prescription and pain medication from loss, damage or theft. My pain provider may not replace lost or stolen prescriptions or medication and he/she may choose to discharge me from the practice. Damaged prescriptions may be replaced at the pain provider's discretion.
21. I will never alter a prescription in ANY way. I understand this is a felony, punishable by incarceration.
22. I authorize the Pain Management provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including New Hampshire's Board of Pharmacy and the DEA, in the investigation of any possible misuse, prescription forgery, sale or any other diversion of my pain medication. I understand that illegal substance use may be reported to the proper authorities. I lose my rights to privacy or confidentiality with respect to these authorizations.
23. I allow my Pain Management provider to receive information from any pharmacy I have used.
24. I will have all my medications filled only at the pharmacy I have listed below. I will inform my Pain Management provider of any pharmacy changes.
25. Pain medications may be continued as long as:
    a. there is acceptable improvement in/maintenance of level of pain and function
    b. pain medications are used according to prescription or provider orders
    c. there are no significant, unmanageable side effects
26. For women: I will notify my provider immediately if I become pregnant. To the best of my knowledge, I am not pregnant at this time nor am I trying to become pregnant.
27. For intrathecal drug administration system patients: I understand the importance of keeping my scheduled pump refill appointments. I understand in the event that my insurance policy will not pay for the medication that I am responsible for paying for my pump medication at the time of refill. I understand that if my pump is not refilled when it is running empty that I risk going through withdrawal and that I risk my health and life if that occurs. I understand the importance of notifying my provider if I hear my pump beeping that it is near to running empty. I accept the responsibility if I allow my pump to run empty.
28. I agree that I will never use any medications prescribed to me by GSPA/GSSC to intentionally cause any harm to myself and to use all such medications only as directed by my GSPA/GSSC provider.
29. I understand that if I fail to adhere, even once, to any of these contract terms that my Pain Management provider may decide to discontinue certain treatment or discharge me from the practice altogether. If discharged, one month's supply of current pain medications and/or anti withdrawal meds may be prescribed and I will be given a list of other pain specialists to contact upon request. I understand that GSPA/GSSC is under no obligation whatsoever to treat me after 30 days from discharge, even if I cannot find another pain provider.

I have read, understand and will comply with this agreement.
I have been given the opportunity to have any questions addressed regarding the above.

Name _____

Pharmacy _____ Town _____ Phone _____

Primary Care Provider _____ Town _____ Phone _____

Signature _____ Date _____

2 copies given to patient
Two copies of this form are to be given to the patient after they sign; one for their records and one for the Pharmacy's records.