PAIN MANAGEMENT AGREEMENT

I, _____ [print patient's name], have agreed to submit to the care of _____ [print physician's name], and/or his associates.

It is my understanding procedures may be performed to intervene with my pain, improve my lifestyle, increase mobility and decrease the use of medications for pain control. The procedures, potential risks and benefits will be explained and all questions answered to my satisfaction. No promise of 100% pain relief has been stated, written or implied.

I am aware of the complications beyond the physicians' control including allergic reactions to medications, damage to any and all body organs up to and including death can occur.

PATIENT RESPONSIBILITIES:

I have informed the physician of any potential or existing medical diseases, surgical problems, allergies to medications, chemical compounds, food, drugs or tape, drug dependency or alcohol dependency, the presence of cardiac pacemakers and involvement in present or previous litigation. It is my responsibility to keep _____ informed of any changes in medication prescribed by my primary physician as well as emergency room treatments or ambulatory care center treatments.

I understand the Surgeon General's statements on smoking with regards to health risk. I am aware that _____ recommends all patients to stop smoking. I assume full responsibility for any harmful, life threatening consequences from continuation of my smoking. I have been made aware that smoking does diminish blood supply to tissues, which can hinder the healing process and exacerbate painful syndromes.

DIAGNOSTIC TESTING:

All medical records will be made available to the physician including office visits, physical therapy reports, psychological evaluations, laboratory tests, x-rays, CAT scans, MRI scans, thermography, bone scan, nerve conduction studies or functional capacity evaluations.

EXAMINATION:

I grant permission to be examined by the physicians and appropriate medical staff in accordance with acceptable standards of medical practice at the time of this evaluation and any subsequent visit as deemed appropriate.

PROCEDURES:

I grant permission for the performance of non-invasive office procedures, including psychometric testing, functional capacity evaluations, range of motion testing, application of transcutaneous nerve stimulators, use of bioelectric stimulation, spray and stretch of muscles and biofeedback. I also grant advanced permission, if indicated, for the use of trigger point injections, intravenous infusions, intramuscular injections and reprogramming of stimulators or refilling of pumps. This consent authorizes _____ or its designee to perform these procedures as dictated by the needs of my medical care within the guidelines of acceptable national standards of medical practice.

PATIENT BILL OF RIGHTS:

A copy of the Patient Bill of Rights has been provided to me. I have also received a copy of the office policy and guidelines.

I have been informed of the medical necessity to follow all instructions, especially not eating prior to procedures, taking medications as prescribed and complying with the paint management team.

CONSULTANT STATUS:

I am aware that _____ physicians function as consultants only. If I don't already have a primary care physician, I understand it to be my responsibility to retain one within 14 days of entering the practices of _____.

SPECIAL BLOOD TESTING:

If a member of the staff of _____, a physician or employee of a home health agency or surgical pain management facility should be stuck with a needle contaminated by my blood or secretions, I hereby authorize appropriate specimens of blood be taken to test for communicable infectious diseases, including but not limited to HIV, Hepatitis and syphilis. I understand the blood samples with be handled according to existing OSHA guidelines established at the facility where the incident took place.

DURATION OF INFORMED CONSENT CONTRACT:

This informed consent contract will stay in effect until I terminate my physician/patient relationship with _____ and/or his associates. I understand that other specialists in the field of pain medicine are available, but have chosen to proceed with _____, and/or his associates. I agree to hold them harmless for any act or complication arising from any procedure listed above not related to an act of medical negligence by _____, and/or his associates. If any dispute should arise I agree to resolve the issue through arbitration.

_____ _____

Physician Signature *Date and Time*

_____ _____

Witness Signature *Date and Time*