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Thank you for choosing HCM Medical Group for your healthcare needs. As a partner in your healthcare, we want to safety provide you with effective and appropriate pain management.

The FDA last year released two Black Box warnings regarding the prescribing of opioid medications in combination with benzodiazepine medications. There are serious risks associated with combining these medications including extreme sleepiness, respiratory depression, coma and even death.

Opioid medications are powerful pain-reducing prescription medications that include oxycodone, hydrocodone and morphine, among other drugs, under both brand and generic names.

Benzodiazepines are drugs typically prescribed for the treatment of neurological and/or psychological conditions, including anxiety, insomnia and seizure disorders.

Although you may have been previously prescribed this combination without negative effects, our practice will not prescribe, under any circumstance, this combination of medication. In addition, we will only prescribe a safe and appropriate dosage of Opioid medications when medically necessary. If you have the expectation to continue this combination of medication and/or dosages outside of what we considered appropriate and safe, we may not be the right providers for your pain management.

For your safety, we also will not prescribe pain medications if you are positive for illicit drugs at any time during treatment. Recommendations will be made to seek treatment for illicit drug use.

Our number one goal is to work with you to find the most appropriate treatment for your pain management. Please review the enclosed medication agreement. Our patients are required to read and agree to this agreement before our providers can provide treatment.

Sincerely,

Ralph Menard, MD
Pain Medicine
Board Certified, American Board of Pain Medicine and American Board of Anesthesia

J. Kaleb Shaw, MD
Pain Medicine
Board Certified, American Board of Physical Medicine & Rehabilitation

Pain Management

Patient's Name _____

Date _____

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What is the main reason for your visit today?

Please check any difficulty in the following activities that apply to you.

□ Getting up from chair □ Using the toilet □ Bathing

□ Getting up from bed □ Eating □ Dressing

□ Other:

Where is the pain located?

□ Head	□ Shoulder	□ Right □ Left □ Both	□ Ankle	□ Right □ Left □ Both
□ Upper Back	□ Elbow	□ Right □ Left □ Both	□ Foot	□ Right □ Left □ Both
□ Lower Back	□ Wrist	□ Right □ Left □ Both	□ Other	
□ Pelvis	□ Hand	□ Right □ Left □ Both		
□ Groin	□ Fingers	□ Right □ Left □ Both		
□ Tailbone	□ Knee	□ Right □ Left □ Both		

Does the pain radiate to any of the following?

□ Head		□ Knee	□ Right □ Left □ Both
□ Eyes	□ Right □ Left □ Both	□ Calves	□ Right □ Left □ Both
□ Shoulder	□ Right □ Left □ Both	□ Toes	□ Right □ Left □ Both
□ Elbow	□ Right □ Left □ Both	□ Buttock	□ Front □ Back □ Right □ Left
□ Hand	□ Right □ Left □ Both	□ Thighs	□ Front □ Back □ Right □ Left
□ Fingers	□ Right □ Left □ Both	□ Other	

What is the description of the pain?

□ Dull	□ Cramping	□ Burning	□ Heaviness	□ Tender
□ Aching	□ Hot	□ Tingling	□ Numbness	□ Shooting
□ Sharp	□ Stabbing	□ Pins & Needles	□ Tightness	□ Other

Are you experiencing pain now? □ Yes □ No

On a scale of 0-10 (0 being "no pain" and 10 being "worst imaginable") Today my pain is a _____

When did the pain start?

□ 1-4 weeks ago	□ 6-9 months ago	□ 3-6 years ago
□ 1-3 months ago	□ 9-12 months ago	□ Over 6 years ago
□ 3-6 months ago	□ 1-2 years ago	□ Other

What caused the pain?

□ Fall □ Surgery □ Lifting □ Accident □ Trauma □ No Event □ Other

Pain Management

Patient's Name _____

Date _____

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Please note any factors that go along with the pain.				
□ Spasms	□ Bowel Dysfunction	□ Lack of Appetite	□ Paralysis	□ Other
□ Poor Vision	□ Bladder Dysfunction	□ Numbness	□ Weakness	
□ Lack of Sleep	□ Erectile Dysfunction	□ Tingling	□ Fatigue	

Factors that releive the pain				
□ Nothing	□ Walking	□ TENS	□ Lying	□ Injections
□ Standing	□ Ice	□ Massage	□ OTC Medications	□ Other
□ Sitting	□ Heat	□ Chiropractor	□ Accupuncture	□ Narcotics

Factors that aggavate the pain			
□ Nothing	□ Walking	□ Coughing/Sneezing	□ Reaching
□ Standing	□ Bending	□ Driving	□ Straining
□ Sitting	□ Stooping	□ Walking	□ Looking Up
□ Lying	□ Climbing Stairs	□ Running	□ Looking Down
□ Other			

Other Therapies				
□ Accupuncture	□ Biofeedback	□ Muscle Relaxers	□ Massage	□ TENS
□ Chiropractor	□ Physical Therapy	□ Psychotherapy	□ NSAIDS	□ RFA
□ Narcotics	□ Radio Frequency Ablation	□ Trigger Point Injection	□ Other	
□ Facet Injection	□ Epidural Steroid Injection	□ Spinal Cord Stimulator		

Any previous Pain Clinic Treatment: □ Yes □ No	Where?
Treatment:	

List any prevous tests related to this problem, performed in the last 12 months:		
□ CT Scan	□ Electromyography/EMG Nerve Study	□ MRI (Cervical, Thoracis or Lumbar)
□ Myelogram	□ Discogram	□ Other

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9 CHAPTER 170

4th Edition: Developed by the Texas Pain Society, August 2017 (www. texaspain.org)

NAME OF PATIENT: _____DATE:_____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement, the use of the word "physician" is defined to include not only my physician, but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers; as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva, or any other testing when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from your care.

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For female patients only:

____ To the best of my knowledge **I am not pregnant.**

____ If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

____ If I am pregnant or am uncertain. I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to this use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: Constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medication(s) to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

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PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

This pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and /or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my physician each time a prescription is written.
____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued.**
____ I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
____ I will use the medication(s) **exactly as directed by my physician.**
____ I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medication(s).
____I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
____ All medication(s) must be obtained at **one pharmacy, when possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed
____ My pain management physician will manage the chronic pain symptoms. All other health related issues must be managed by my primary care physician.
____ I understand that my medication(s) will be refilled on a regular basis, Understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
____ Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
____ I will receive controlled substance medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
____ If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
____ **I agree to submit to urine and / or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substances(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specialized in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

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____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
____ I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
____ I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.
____ I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of treatment.
____ I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.
____ I understand many prescription medication for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.
____I understand that the medications prescribed to control my pain, including opioids and others like gabapentin or Lyrica, have many side effects, including drowsiness and may affect my ability to think and react normally. As such I understand that I am advised not to drive or use heavy equipment or machinery while taking these medications.

I certify and agree to the following:

____ 1) I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
____ 2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
____ 3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved I consent to chronic pain treatment, since I realized that it provides me an opportunity to lead a more productive and active life.
____ 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**
____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

_____ _____

Patient Signature Physician Signature (*or Appropriately Authorized Assistant*)

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Prescription Policy

In order to initially prescribe a medication, we are required by law to see and examine the patient. To have a previously ordered prescription refilled, please ask the pharmacy to fax a request to us at (830) 990-1408.

Please note: It may be necessary for your physician to see you before a prescription can be refilled.

Routine prescriptions will not be handled after office hours or on weekends. Office hours are Monday-Thursday 8:00 AM – 5:00 PM, we are closed for lunch from 12:00 PM – 1:00 PM. Fridays we are open from 8:00 AM – 12:00 PM.

Please allow 72 hours for all refill requests.

By signing below, I have read and understand the scope of my consent and that I authorize HCM Medical Group and its affiliated providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other affiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and HCM Medical Group staff, and it may include prescription history from the last several years.

_____

Patient / Legal Representative

_____

Relationship to Patient

_____

Date