

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 medications 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.

For female patients only: To the best of my knowledge I am NOT pregnant. 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 to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That 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:

1. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medications(s) may be discontinued.
2. I will disclose to my physician *all medication(s)* that I take at any time, prescribed by *any* physician. This disclosure will include any herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
3. I will receive controlled substance pain 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.
4. I will use *ONE* pharmacy, where possible, to obtain all controlled substances prescribed by my physician. Should the need arise to change pharmacies; Pinnacle Pain Medicine will be notified. In addition, I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

Pharmacy: Walgreens Phone Number: 214 388 4951
Dallas @ Jim Miller, Samuel Rd

5. I will use the medication(s) *exactly* as directed by my physician.
6. I will not use MARIJUANA for medicinal or recreational purposes while receiving controlled substance prescriptions, unless there is a change in Texas legislation to legalize it for medicinal use.
7. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications. I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.

RD 05/23/2013