ANCHOR SPINE & JOINT

PATIENT INFORMATION:					
PATIENT:	LAST NAME:	FIRST NAME:	M.I.	DATE OF BIRTH:	SEX:
					☐ MALE ☐ FEMALE

ADDRESS:	STREET:	CITY/STATE:	ZIP CODE:

HOME PH #:		CELL PH #:		E-MAIL:	
RACE:	☐ CAUCASIAN	☐ HISPANIC	☐ ASIAN	☐ OTHER	
	☐ AFRICAN AMERICAN	☐ NATIVE AMERICAN	☐ REFUSED TO DISCLOSE		

REFERRAL INFORMATION:			
PRIMARY CARE PHYSICIAN:		REFERRING PHYSICIAN:	

EMERGENCY CONTACT INFORMATION:					
NAME:		PHONE NUMBER:		RELATIONSHIP:	

COMMERCIAL HEALTH INSURANCE INFORMATION:			
PRIMARY INS. NAME:		SECONDARY INS. NAME:	
POLICY ID:		POLICY ID:	
GROUP ID:		GROUP ID:	
POLICY HOLDER NAME:		POLICY HOLDER NAME:	
POLICY HOLDER DOB:		POLICY HOLDER DOB:	
RELATIONSHIP:		RELATIONSHIP:	

INSURANCE INFORMATION:			
IS YOUR PAIN DUE TO AN AUTO ACCIDENT? Y N		PERSONAL INJURY CASE? Y N	WORKMAN'S COMPENSATION CASE? Y N
DATE OF INJURY:		CLAIM NUMBER:	
INSURANCE COMPANY:		POLICY HOLDER NAME/DOB:	
ADJUSTER NAME:		ADJUSTER PHONE #:	
ATTORNEY NAME:		ATTORNEY PHONE #:	

HOW MAY OUR OFFICE CONTACT YOU?: (CIRCLE ONE)	HOME PH: YES OR NO	CELL PHONE: YES OR NO	
MAY OUR OFFICE LEAVE A MESSAGE ON YOUR HOME PHONE?:	YES OR NO		
MAY OUR OFFICE LEAVE A MESSAGE ON YOUR CELL PHONE?:	YES OR NO		
NOTICE OF PRIVACY PRACTICES, WOULD YOU LIKE A COPY?:	YES OR NO		

I understand that the physicians and staff of Anchor spine and Joint will only be evaluating my condition as it relates to my pain. Any condition which is not specifically pain-related must be followed and evaluated by my primary care physician.

I understand that the procedures and medications which may be prescribed can potentially have adverse effects on the status of one's fertility as well as a developing fetus. I will notify my physician if there is any change in my fertility status or pregnancy status.

I understand that it may be at times difficult to obtain prompt consultation with the physicians or staff. If there is ever a significant deterioration on my function or progression of symptoms, I will seek prompt medical attention elsewhere.

I acknowledge that I may request at anytime a copy of notice of privacy practices of this office, which outlines how confidential patient information will be used, disclosed, and protected.

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

PATIENT NAME:		DATE OF BIRTH:	

PAIN DESCRIPTION:

PAIN LEVEL:	NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN
My pain is: (Circle)	Constant Intermittent Improving Worsening
Onset of Pain:	Due to MVA: YES NO Due to Injury: YES NO
Describe your pain:	☐ Dull/Aching ☐ Sharp/Stabbing ☐ Hot/Burning ☐ Pins/Needles/Tingling ☐ Cramping ☐ Squeezing ☐ Throbbing ☐ Shooting/Radiating
What activities makes pain WORSE:	☐ Prolong Sitting ☐ Prolong Walking ☐ Prolong Standing ☐ Reaching ☐ Lifting ☐ Bending ☐ Range of Motion ☐ Other: _____
What activities makes pain BETTER:	

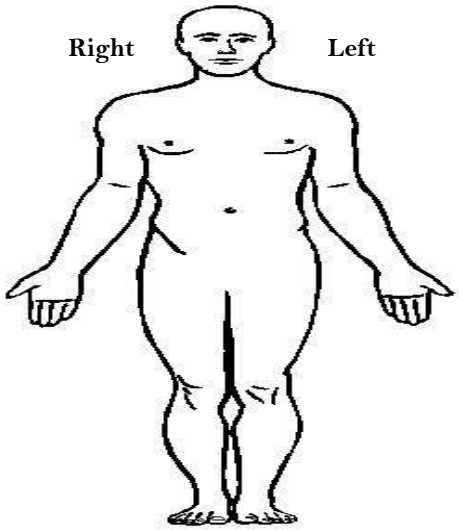
ASSOCIATED SYMPTOMS: Currently Experiencing (Circle)

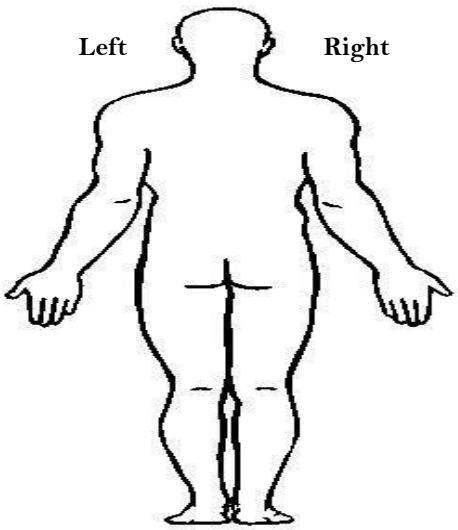
Numbness/Tingling Location:			
Weakness Location:			
Joint Swelling	Stiffness	Leg Swelling	Leg Pain
Difficulty Walking	Balance Problems	Bowel Incontinence	Bladder Incontinence
Fatigue	Other:		

AUTO ACCIDENT INJURY

Date of Injury:			
Have you had previous injuries?		YES	NO
Have you seen other providers?		YES	NO
The patient was the:		DRIVER	PASSENGER
Patient was wearing seat belt:		YES	NO
Patient was holding the steering wheel:		YES	NO
Patients' air bags deployed:		YES	NO
Patient hit head/Suffered a head trauma:		YES	NO
Patient reports loss of consciousness:		YES	NO
Patients' vehicle was:		STOPPED	MOVING
Type of accident:	REAR END	T-BONE	HEAD ON
Post-Accident, the patient went where:	HOME	HOSPITAL	URGENT CARE
Type of Treatment:			

Circle Pain Area:





PRIOR TREATMENTS				
IMAGING COMPLETED				
X-RAY: Where?_____	MRI: Where?_____	CT SCAN: Where?_____	EMG/NCV(NERVE STUDY)	
INJECTIONS:	BETTER	WORSE	NO CHANGE	TYPE:
SPINE SURGERY:	BETTER	WORSE	NO CHANGE	TYPE/YEAR?

PHYSICAL THERAPY:	BETTER	WORSE	NO CHANGE	LAST SESSION:
CHIROPRACTOR:	BETTER	WORSE	NO CHANGE	LAST SESSION:
ACUPUNCTURE	BETTER	WORSE	NO CHANGE	LAST SESSION:
BRACE:	BETTER	WORSE	NO CHANGE	OTHER:
TENS UNIT:	BETTER	WORSE	NO CHANGE	OTHER:
HEAT/ICE:	BETTER	WORSE	NO CHANGE	OTHER:
MASSAGE THERAPY:	BETTER	WORSE	NO CHANGE	OTHER:

CURRENT MEDICATIONS:

NAME:	DOSE/DIRECTIONS:	NAME:	DOSE/DIRECTIONSl
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PRIOR MEDICATIONS:

ANTI-INFLAMMATORY:	HELPED:	PAIN MEDICATIONS:	HELPED:
Naproxen (Aleve)	YES NO	Hydrocodone	YES NO
Ibuprofen (Advil,Mortin)	YES NO	Oxycodone	YES NO
Diclofenac (Voltaren)	YES NO	Tramadol	YES NO
Celebrex	YES NO	Tylenol w/ Codeine	YES NO
Lido/Flector Patch	YES NO	Tylenol (Acetaminophen)	YES NO
MUSCLE RELAXANT:	**HELPED:**	**NERVE MEDICATIONS:**	**HELPED:**
Cyclobenzarprine (Flexeril)	YES NO	Gabapentin	YES NO
Skelaxin (Metaxolone)	YES NO	Lyrica	YES NO
Methocarbarmol (Robaxin)	YES NO	Cymbalta	YES NO
Tizanidine (Zanaflex)	YES NO	Amitriptyline	YES NO

ALLERGIES

ANY KNOWN ALLERGIES?:			
Have you ever had an allergic reaction to:	CONTRAST: YES NO	IODINE: YES NO	SHELLFISH: YES NO
Dental Numbing Medications: YES NO		Latex: YES NO	
Have you ever had a bad reaction to anesthesia?: YES NO			

PAST MEDICAL HISTORY

High Blood Pressure	Diabetes	Heart Attack	Heart Disease	Stroke
Rheumatoid Arthritis	Gout	Kidney Disease	Liver Disease	Cancer
Anxiety Disorder	HIV/AIDS	Osteoporosis	Hepatitis (A , B , C)	Depression
Peptic Ulcer Disorder	Bipolar Disorder	Attention Deficit	Schizophrenia	Anemia
OTHER:				

PAST SURGERIES: LIST ANY AND ALL SURGERIES

SOCIAL HISTORY			
Occupation:		RETIRED	DISABLED
Tobacco Usage:	YES NO	What age did you START:	
If YES : How many packs per day:		What age did you QUIT:	
Alcohol Consumption:	YES NO	Do you drink alcohol socially?	YES NO

FAMILY HISTORY			
Alcohol Abuse	YES NO	Diabetes	YES NO
Illegal Drug Use	YES NO	Heart Disease	YES NO
Prescription Drug Abuse	YES NO	Hypertension	YES NO
Stroke	YES NO	Cancer	YES NO
Other:			

REVIEW OF SYSTEMS								
GENERAL:			**ENDOCRINE:**			**EARS/NOSE/THROAT:**		
Loss of Appetite	YES	NO	Thyroid Disease	YES	NO	Hoarseness	YES	NO
Recent Weight Loss	YES	NO	Heat Intolerance	YES	NO	Trouble Swallowing	YES	NO
Fever or Chills	YES	NO	Cold Intolerance	YES	NO	Hearing Loss	YES	NO
RESPIRATORY:			**CARDIOVASCULAR:**			**HEMATOLOGIC:**		
Shortness of Breath	YES	NO	Chest Pain	YES	NO	Easy Bruising	YES	NO
Chronic Cough	YES	NO	Palpitations	YES	NO	Easy Bleeding	YES	NO
KIDNEY/BLADDER:			**EYES:**			**PSYCHIATRIC:**		
Painful Urination	YES	NO	Blurred Vision	YES	NO	Depression	YES	NO
Blood in Urine	YES	NO	Double Vision	YES	NO	Suicidal Thoughts	YES	NO
Kidney Problems	YES	NO	Loss of Vision	YES	NO	Drug/Alcohol Abuse	YES	NO
NEUROLOGICAL:			**SKIN:**			**GASTROINTESTINAL:**		
Headaches	YES	NO	Frequent Rashes	YES	NO	Constipation	YES	NO
Seizures	YES	NO	Blood Clots	YES	NO	Heartburn	YES	NO
Dizziness	YES	NO	Lumps	YES	NO	Nausea/Vomiting	YES	NO

VITALS			
Pain Level:	RR:	Oxygen:	HR:
BP:	Weight:	Height:	Temp:

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

MEDICAL RECORDS RELEASE AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I.		DATE OF BIRTH:

ADDRESS:	STREET:	CITY/STATE:	ZIP CODE:

INFORMATION TO BE RELEASED: (CHECK ALL ITEMS TO BE RELEASED)

☐ Entire Record

☐ Last 3 Office Notes

☐ Last 3 Procedure Notes

☐ Last 3 UDS Results

☐ Discharge Letter

☐ Operative Reports

☐ MRI/XRAY/CT SCAN/EMG STUDY

☐ Other: _____

Period From: _____

Special Records: I understand that protected health information related to my diagnosis or treatment for AIDS/HIV, psychiatric care treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate boxes below.

AIDS/HIV Information:	☐ YES, disclose	☐ NO, do not disclose
Psychiatric Care/Treatment:	☐ YES, disclose	☐ NO, do not disclose
Treatment for Drug/Alcohol Abuse:	☐ YES, disclose	☐ NO, do not disclose

PURPOSE/USE OF REQUESTED INFORMATION: Continuation of Treatment

RELEASE INFORMATION TO:

Anchor Spine and Joint
10726 Ketchum Valley Drive, Riverview, FL 33579
110 S. MacDill Ave, Suite 300, Tampa, FL 33609
7800 66th Street N, Suite 305, Pinellas Park, FL 33781
13543 State Road 54, Suite B, Odessa, FL 33556
Phone: 813-331-4465 Fax: 813-280-4855

AUTHORIZATION:

For personal requests: There will be a charge of $1.00 per page from 1-25, and $.25 per page 26+ fee for all requests on paper (plus the cost of postage and envelope).

For Doctor to Doctor requests: There will be no fee. By default , the past two (2) years of pertinent information will be sent.

- I understand that my authorization will automatically expire on one (1) year after the date of signature on this form.
- I understand that I may revoke this authorization at any time, by notifying Anchor Spine and Joint in writing.
- I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer subject to the protections of the privacy standard.
- My refusal to sign this authorization will not affect enrollment, eligibility for benefits, payment, or my ability to receive treatment.
- I understand that I may inspect or copy the information that is used or disclosed.

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

AUTHORIZATIONS FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

By signing below, I authorize Anchor Spine and Joint, its agents and employees ("provider"), to use and/or disclose any and all of my protected health information ("records") on my behalf, of any kind and description, to the following ("recipient"):

Recipient Name:	Relationship:
	Primary Care Provider
	Relative/Friend/Spouse
	Relative/Friend/Spouse
	Relative/Friend/Spouse

I also authorize provider to release my protected health information to my insurance, primary care provider, referring provider, hospitals, diagnostic centers, and/or laboratories that may require this information for continued care and authorize provider to transmit this information through electronic means.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION:

I understand that neither provider nor recipient may condition treatment, payment, enrollment or eligibility for the benefits on whether I sign this authorization. In addition, I understand the recipient may redisclose the records and that the records may no longer be protected by the federal privacy regulations.

I acknowledge and agree that the protected health information authorizes to be disclosed under this authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnoses or treatment for HIV, HIV related diseases and communicable disease related information. With respect to any communicable disease related information protected by state confidentiality rules and disclosed under this authorization, recipient is prohibited from making any further disclosure of this information unless future disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

I understand I have the right to refuse to sign this authorization, writing, at any time and that I do not have to sign this authorization to receive treatment at Anchor Spine and Joint. When my information is used of disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal health insurance portability and accountability act (HIPPA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is Anchor Spine and Joint, Attn: Privacy Officer, 10726 Ketchum Valley Drive, Riverview, FL 33579.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this authorization, this information has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42. C.F.R. part 2. A general authorization for the release of medical or other information is NOT enough for the purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization will remain effective until one year following the dates set forth below, or, if no date is set forth below, the date Anchor Spine and Joint receives executed authorization, at which time this authorization will be used, disclosed, and protected.

Patient or Legal Representative Printed Name:	Date:
Patient or Legal Representative Signature:	

FINANCIAL POLICY

Our financial policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide the highest quality medical care for our patients.

Appointments: Missed appointments and late arrivals: If you are more than 15 minutes late, we reserve the right to reschedule your appointment. If you are more than 60 minutes late, no show for an appointment, or do not give cancellation notice at least 24 hours in advance, you will be responsible for a missed appointment fee. The first missed appointment occurrence will not be charged a fee. Any additional missed appointments will result in a missed appointment fee as follows: Missed office visits are subject to a $100 charge, missed procedure are subject to a $250 charge. These charges are your responsibility and will not be billed to any insurance carrier. It is at the provider's discretion to determine whether you will be dismissed from the practice due to missed appointments.

INSURANCE PAYMENTS

Financial responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

Coverage changes and timely submission: It is your responsibility to in form us in a timely manner of any changes to your billing or insurance information. There is a time limit with in which Anchor Spine and Joint must submit a claim on your behalf to your insurer. If we are unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

Self-pay: If you have no health insurance or governmental sponsored program and are not tr eating under an ABN or authority to treat, you will be considered a self-pay patient. Your payment may be made pursuant to a time of service discount negotiated with the practice and paid prior to receipt of any service.

BENEFITS AND AUTHORIZATION

Insurance plan participation: We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of net work charges may have higher deductibles and co-payments.

Prior authorization and non-covered services: Anchor Spine and Joint may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefit s and authorized by your insurer. As a courtesy to our patients, Anchor Spine and Joint makes a good faith effort to determine if services are covered by your insurance plan, and, if so, whether prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Please be aware some and perhaps all the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for the area.

Out of network payments: If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Anchor Spine and Joint, immediately.

ACCOUNT BALANCES AND PAYMENTS

Reassignment of balances: If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

Returned check: Returned checks will be subject to a $38 returned check fee.

I have read and understand the financial policy of Anchor Spine and Joint, and I agree to abide by its terms. I understand that this financial policy is binding upon me, my estate, executors and/or administrators, if applicable. I hereby authorize Anchor Spine and Joint, to release any medical information necessary to process all claims for reimbursement on my behalf. I hereby assig n all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Anchor Spine and Joint or named physicians or affiliates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over Medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above named entity. I understand that I am financially responsible for all services I receive from Anchor Spine and Joint. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

Patient or Legal Representative Printed Name:	**Date:**
Patient or Legal Representative Signature:	

AGREEMENT FOR LONG-TERM OPIOID/ NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN

Patient Name: _____ Date of Birth: _____

You have agreed to receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living. Alternative therapies and medications have been explained and offered to you. You have chosen opioid/ narcotic therapy as one component of treatment. You must b e aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during your treatment, you should contact your physician. The use of cigarettes demonstrates a dependence on nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program.

SIDE EFFECTS: Side effects are normal physical reactions to medications. Common side effects of opioids/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, an d confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried, or they may be discontinued . You should NOT:

- **Operate a vehicle or machinery if the medication makes you drowsy**
- **Consume any alcohol**
- **Take any other non-prescribed sedative medication**

The effects of alcohol and se datives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even death. Driving while taking opioids/narcotics is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is possible that you could be considered DUI if stopped by law enforcement while driving. Opioids have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects. Your hormone levels can be monitored during your treatment. Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

RISKS: Dependence: Physical dependence is an expected side effect of long-term opioid/narcotic therapy .This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome . This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

Tolerance: Tolerance to the pain-relieving effects of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your under lying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain relieving effect; upward adjustments during this period are not view ed as tolerance.

Increased Pain (Hyperalgesia): The long-term effects of opioids/narcotics on the bodies own pain fighting systems are unknown . Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an increased sensitivity to pain . Sometimes individuals who have been on long term opioids/narcotics, but who continue to have pain, note decreased pain after several weeks off of the medications.

Addiction: Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following: Impaired control over drug use, compulsive use, continued use despite harm, craving.

Most patients with chronic pain who use long term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy . Therefore, they are NOT addicted . Physical dependence is NOT the same as addiction.

RISK TO UNBORN CHILDREN: Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

LONG TERM SIDE EFFECTS: The long term effect of opioid/narcotic therapy is not fully known. Most of the long term effects have been listed above. If you have additional questions regarding the potential long term effects of opioid/narcotic therapy, please speak with your physician .

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS:

Your medication will be prescribed by your physician for control of pain . Based on your in dividual needs, you will be provided with enough medication on a 2 week, or monthly basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will NOT be "called in" to the pharmacy.

You agree:

- **To be seen every 2weeks or every month during course of therapy**
- **Understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.**
- **Understand that opioid/narcotic medication is strictly prescribed for you and should NEVER be given to others.**
- **Fill opioid/narcotic prescriptions at one pharmacy.**
- **Secure your opioid/narcotics in safe, locked source to prevent loss/theft . You are responsible for any loss/theft. Lost, stolen or destroyed prescriptions will not be replaced and may result in discontinuation of treatment.**
- **Obtain opioid/narcotic medication from one prescribing physician or that physician' s substitute if your prescribing physician is not available and your prescribing physician has authorized his/her substitute to provide treatment.**
- **Submit to an initial examination and evaluation, to routine examination and evaluation on a monthly basis or regular basis (but no less than once every 3 months), and to examination and evaluation at the direction of your physician.**
- **Submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. You also agree that other doctors and law enforcement may be notified of the results.**
- **NOT to call the physician for refills or replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement request will be addressed during regular business hours only.**
- **That if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. You further understand and agree that you are solely responsible for your own medications.**
- **To bring all prescription medications in their bottles or containers to the office during regularly scheduled visits.**
- **Provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.**

For patients taking methadone: methadone has significant interactions with many other medications. Some of these medications may reduce your bodies ability to metabolize methadone, thus increasing the methadone in your body, which could be dangerous. Therefore, you must notify our office of all medications prescribed for any condition while taking methadone.

OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

Develop progressive tolerance which cannot be managed by changing medications, experience unacceptable side effects which cannot be controlled, experience diminishing function or poor pain control, develop signs of addiction, abuse of any other controlled substance (this may be determined by random blood/urine testing), obtain and or use street drugs, increase your medication without the consent of your physician, either refuse to stop or resume smoking, obtain opiates/narcotics from other physicians or sources, fill prescriptions at other pharmacies without explanation, sell, give away, or lose medications, fail to submit to routine examination and evaluation on a monthly basis or regular basis, or as directed by your physician, fail to bring your prescription medications to your regularly scheduled visits, fail to submit to blood/urine testing as directed, call for refills during evenings, weekends or holidays, violate any of the terms of this agreement

By signing below, patient acknowledges and agrees that I have read and fully understand the physician patient informed consent and agreement for long term opioid/narcotic therapy for the treatment of chronic pain . I have been given the opportunity to ask questions about the proposed treatment (including no treatment) potential risks, complications, side effects, and benefits. I knowingly accept and agree to assume the risks of the proposed treatment as presented and I agree to abide by the terms of this agreement.

Patient or Legal Representative Printed Name:	**Date:**
Patient or Legal Representative Signature:	
Medical Provider Signature:	**Date:**