PRECISION
ORTHOPEDICS & SPORTS MEDICINE

Registration Form

Patient's Information

Last Name:_____First Name: _____Middle Initial:_____

Date of Birth:_____ Primary Contact Number: □ Cell □ Home □ Work

Cell Phone: _____ Home Phone:_____ Work Phone:_____

Email address: _____

Emergency Contact

Full Name:_____Relationship:_____

Primary Contact Number:_____ □ Cell □ Home □ Work

Alternate Contact Number:_____ □ Cell □ Home □ Work

Contact Preferences

I wish to be contacted in the following manner: (check all that apply)	OK To leave a message with Detailed information?	Leave message with call back number only
□ Cell □ Home □ Work □ Email	□ Cell □ Home □ Work □ Email (see email request form)	□ Cell □ Home □ Work □ Email

Automated Appointment Reminders

Precision Orthopedics has adopted an outside appointment reminder system of which will send you appointment confirmation requests via email 5 days prior, preferred phone two days prior, and a text one day prior to your appointment with limited information for the purpose of notifying you of your appointment time and the provider to which you will be seeing. I authorize my healthcare provider to disclose to this third party service limited Protected Health Information regarding my upcoming appointments. I consent to receiving these messages via email, phone and and/or text (text message rates will apply).

Disclosure of Medical Information

I hereby give permission to Precision Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

□ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions

Notice of Privacy Practices

_____ I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
(Initials)

Facsimile Authorization for Coordination of Care

I, the undersigned, authorize POSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary **coordination of care** for the patient listed below. **Medical records requests require separate form and authorization from this Facsimile Authorization**. I may revoke this authorization by giving POSM five (5) days written notice. This revocation may be by facsimile transmission; however, a **written copy of the revocation must be mailed to POSM as well.**

Signature:_____Date: _____

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Patient Name: _____

Patient Consent for Treatment

I, knowing that I have a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care to such diagnostic, medical, and/or office based surgical treatment under the general and specific instruction of POSM's physicians and/or any other licensed healthcare service provider, assistants and/or designee as is necessary in their judgment. I also acknowledge that no guarantees have been made to me as to the results of the treatments or examination and that the possible risks, benefits, and complications of the said procedure have been discussed with me by the service provider.

Prescription Refill Policy

Prescriptions will only be written and refilled from Monday through Friday 8:00 am to 4:30 PM. **No prescriptions will be written or called in after these hours or on holidays and weekends**. Therefore, it is your responsibility to closely monitor your supply of medications. We recommend that you make your prescription requests at least 48 hours prior to running out of your prescriptions.

Financial Disclosure Notice to Beneficiary

This is a notice informing you that some and/or all physicians of Precision Orthopedics & Sports Medicine could have an ownership interest in these entities. Your physician's ownership interest means that your physicians may benefit from choosing to perform surgical procedures at one of the following facilities: Baylor Las Colinas, Methodist Southlake, Blue Star Surgery Center, and Pine Creek Medical Center. Because of this, your physician hereby advises you that you have the right to choose to be treated at a different facility, should you desire, and he will make such arrangements, if possible. These facilities are separate legal entities from Precision Orthopedics and Sports Medicine. You will receive a separate billing from each entity.

Financial Agreement

We are dedicated to providing the best possible care to you and regard your understanding of our financial policies an essential element of your care and treatment. This financial policy is intended to clarify these issues.

- Please present your insurance card and photo ID at each appointment. You must provide your most current billing address, all available telephone numbers, email address and any important contact information. If this information changes. it is your responsibility to contact us with your updated information. Your insurance policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, including obtaining the necessary referral authorizations, they may not pay for all or part of your care, and you may not qualify for any managed care discounts. If your insurance company does not pay within 60 days of the date of service, you may be expected to pay for the balance in full.
- Self-pay patients: There is a minimum deposit of **$350.00** for New Patients and **$200.00** for follow-up patients due upfront for all private pay patients for professional services to include office visit, X-ray, and injections if indicated; durable medical equipment and/or special services will be billed separately. All deposits must be cash or credit card only – no checks accepted. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency. Payment is due at the time the service is rendered unless other arrangements have been made in advance. We accept cash, checks, VISA, MasterCard, Discover and AMEX.
- Some durable medical equipment and/or supplies may not be covered by your insurance requiring payment at time of service.
- We charge for certain forms such as Disability and FMLA forms, as well as medical records.
- Responsibilities for payments for patients who are minor children, whose parents are divorced, rest with the parent who seeks the treatment (This parent is the guarantor.) Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of POSM.
- We bill participating insurance companies as a courtesy to you. If your insurance company requires your social security number to file a claim, you will be required to provide it or pay for services at time of service. **We require that payment of deductibles, co-pays, surgery deposits, non-covered items and co-insurance be paid at the time of service. You are financially responsible for services not covered by your insurance company.**
- We do not bill third party insurance companies such as Auto or Liability Insurance; payment is expected in full at time of service. We will provide you with the necessary paperwork and forms to you to submit your claim to your insurance carrier.
- For ERISA, Out-Of-Network and Self-Funded plans, and Workers Compensation I hereby assign and convey directly to Precision Orthopedics & Sports Medicine, as my designated authorized representative, all insurance reimbursement for services rendered by POSM regardless of its network participation status. I authorize POSM and its billing representatives to negotiate, discuss, appeal and in any other way communicate with my insurance company in determining the final payment for services I received. POSM and its billing representative has full authorization to accept or reject any proposed reimbursement proposal, act in whatever way necessary to accomplish the final adjudication of any and all claims, and the results of that determination is binding.
- If you have a balance after we receive payment from the insurance company, we will mail you a statement to the billing address you provide. Payment in full is due upon receipt. Patients with an outstanding balance 60 days or more overdue must make a payment arrangement prior to scheduling appointments.
- Appointment cancellations within 24 hours of the scheduled time may result in a $50.00 charge. Failure to notify us 48 hours before canceling a surgery may result in a $250.00 charge. Rescheduled surgery will result in a $250.00 deposit that will be added to the surgery amount if surgery is proceeded with, however, if the rescheduled surgery is canceled that deposit will be forfeited. Returned checks for any reason will result in a $35.00 charge.

I/we assign to POSM, and Health care providers, and authorized direct payment to Facility(s) all insurance benefits or Medicare benefits which may be entitled. This assignment includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injured caused by a third party.

I / we agree to pay Facility(s) for any and all charges not paid pursuant to this assignment. I have read and POSM Patient Consent, Prescription refill, and Financial Policy and agree to abide by its guidelines.

_____ _____

Signature of Patient/Parent/Legal Representative Date

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Patient Health History Form

(Please acknowledge each section; simply put "N/A" if it does not apply)

Last Name _____ **First Name** _____ **Date of Birth**_____

Primary Care Physician (full name): _____ **Do you want a report sent to your PCP?** □ yes □ no

Who referred you to us (full name)?_____

Pharmacy: Name_____ City_____ Phone #_____

Chief Complaint: What is the main reason for your visit today? Describe problem in detail. (What Hurts)

_____

_____

_____

Side: □Left □Right □Both

How long have you had pain? □_____Weeks □_____ Months □_____Years **Date of Injury:**_____

What is your pain quality? □Dull □Sharp □Achy □Burning

Where is your pain? □Anterior (Front) □Posterior (back) □Lateral (Outside) □Medial (inside)

When is pain the worst? □Morning □Evening □After Strenuous Activity □At Night (interferes with sleep)

Pain Level: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What actions/activities make the problem worse? □ Walking □ Standing □ Running □ Bending □ Lifting □ Reaching □ Overhead Activity □ Driving □ Sitting □Other:_____

What actions/activities make the problem better? □ Resting □ Ice □ Heat □ Elevation □ Pain Meds □ Activity □ Other_____

Are there any other associated signs or symptoms? □ Weakness □ Numbness/Tingling □ Radiating Pain □ Instability

Have you had any diagnostic studies or treatments for this problem? If so, when and where?

□ X-ray □ MRI □ EMG □ CT □ Ultrasound

□ Physical Therapy

□ Injections □ Bracing □ Surgery: _____

□ Other_____

Are there any specific treatment options that brought you to us? (i.e. Stem Cell, Visco-supplementation, PRP, PT/OT, etc)

_____

_____

Past Medical History

Denies Past Medical History

□ Acid Reflux
□ A.D.H.D./A.D.D.
□ Alzheimer's Disease
□ Anemia
□ Asthma
□ Bipolar Disorder
□ Bleeding Disorder
□ Blood Clots
□ Cancer_____
□ Cholesterol
□ Concussion
□ Congestive Heart Failure
□ Crohn's Disease
□ Diabetes – Type ____
□ Digestive Problems
□ Emphysema
□ Gout
□ Grave's Disease
□ Heart Attack
□ Heart Problems
□ Hepatitis
□ Herpes Zoster
□ High Blood Pressure
□ HIV or AIDS
□ I.B.S.
□ Kidney Problems
□ Leukemia
□ Liver Problems
□ Lung Problems
□ Lupus
□ Mental Illness
□ Morbid Obesity
□ Neoplasm, Benign
□ Neoplasm, Malignant
□ Other_____
□ Pneumonia
□ Schizophrenia
□ Seizures
□ Sleep Apnea
□ Stomach Ulcer
□ Stroke
□ Thyroid Disorder
□ Tuberculosis

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Patient Health History Form

(Please acknowledge each section; simply put "N/A" if it does not apply)

Past Orthopedic Medical History

☐ ***Denies Past Orthopedic Medical History***

_____

_____

Previous Surgical History:

☐ ***Denies any Past Surgeries***

☐ Ankle Surgery	☐ Foot Surgery	☐ Lung Surgery	☐ Stomach Surgery
☐ Arm Surgery	☐ Hand Surgery	☐ Neck Surgery	☐ Thyroid Surgery
☐ Back Surgery	☐ Head Surgery	☐ Neuro Surgery	☐ Urology Surgery
☐ Breast Surgery	☐ Heart Surgery	☐ Other_____	☐ Vascular Surgery
☐ Colon Surgery	☐ Hip Surgery	☐ Reproductive Surgery	☐ Wrist Surgery
☐ Ear/Nose/Throat Surgery	☐ Knee Surgery	☐ Shoulder Surgery	
☐ Elbow Surgery	☐ Leg Surgery	☐ Skin Surgery	

Family History

☐ ***Denies any Family Medical History***

☐ Alcoholism	☐ Cancer_____	☐ Kidney Problems	☐ Respiratory Conditions
☐ Anemia	☐ Diabetes	☐ Leukemia	☐ Seizures
☐ Arthritis	☐ Gout	☐ Mental Illness	☐ Stroke
☐ Asthma	☐ Heart Problems	☐ Musculoskeletal Diseases	☐ Thyroid
☐ Blood Disorders	☐ Hypertension	☐ Other_____	

List all medications you are taking including vitamins or herbal supplements: ☐ ***None*** ☐ ***See Attached Listing***

_____

_____

_____

_____

List all known drug allergies: _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐ Common Law Marriage ☐ Domestic Partner

Work Status: ☐ Occupation_____ ☐ Disabled ☐ Retired ☐ Unemployed ☐ Student ☐ Homemaker

Are you Pregnant? ☐yes ☐no
Work related? ☐yes ☐no Date of Injury:_____Occupation: _____
Sports related? ☐yes ☐no Date of Injury:_____
Motor Vehicle Accident related? ☐yes ☐no Date of Accident:_____

Do you drink alcohol? ☐ No Alcohol ☐Yes, daily (___drinks per day) ☐ Yes, socially (___drinks per week)
Do you use tobacco? ☐ Never ☐ Currently (____ pack(s) per day) ☐ Formerly
Drug overuse/abuse: ☐ Never ☐ Currently ☐ In the Past

How Did You Hear About Us (please select all that apply):

☐ ER/Urgent Care (please indicate which hospital/urgent care)_____ ☐ Family/Friend_____
☐ Primary Care Doctor ☐ Other Physician Referral_____ ☐ Other POSM Doctor_____
☐ POSM website ☐ Google ☐ Bing ☐ Other Website_____
☐ Social Media ☐ Facebook ☐ Instagram ☐ Twitter
☐ Magazine ☐ Southlake Style ☐ Living Magazine ☐ Other Magazine/Publication_____
☐ Community Event_____ ☐ Sporting Event_____ ☐ Other Event _____
☐ Southlake Chamber of Commerce ☐ Irving Chamber ☐ Irving Hispanic Chamber ☐Coppell Chamber
☐ Insurance Carrier Recommended ☐ Saw the Building ☐ Workers' Compensation

Are you interested in learning more about Advance Directives or a Living Will? No

By signing below I am verifying that the information provided above is complete and accurate.

Signature: _____ **Date:** _____

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REVIEW OF SYSTEMS

Last Name _____ **First Name** _____ **Date of Birth** _____

Please check any symptoms that you are currently experiencing.

Denies any current review of system symptoms

Constitutional:
- □ Chills
- □ Fever
- □ Headache
- □ Weight Gain
- □ Weight Loss
- □ Fatigue
- □ Body Aches
- □ Night Sweats

Eyes:
- □ Blurred Vision
- □ Double Vision

Throat:
- □ Sore Throat
- □ Difficulty Swallowing

Ears
- □ Ear Infection
- □ Nasal Congestion
- □ Hearing impaired

Nose:
- □ Nasal Congestion
- □ Nose Bleeding
- □ Sinus pain

Respiratory:
- □ Shortness of Breath
- □ Wheezing
- □ Cough

Gastrointestinal:
- □ Abdominal Pain
- □ Constipation
- □ Jaundice
- □ Diarrhea
- □ Nausea/Vomiting
- □ Ulcers
- □ Laxative use

Genitourinary:
- □ Urine Hesitancy
- □ Incontinence
- □ Urinary retention
- □ Blood in urine

Neurologic:
- □ Blackouts
- □ Dizziness
- □ Tingling/Numbness
- □ Seizures
- □ Tremors
- □ Sciatica
- □ Muscular Weakness

Skin:
- □ Boils
- □ Itching
- □ Redness
- □ Skin Rash

Psychiatric:
- □ Depression
- □ Difficulty Sleeping
- □ Anxiety

Musculoskeletal:
- □ Back Pain
- □ Joint Swelling
- □ Joint Pain
- □ Neck Pain
- □ Ankle Instability
- □ Restricted motion
- □ Muscle Cramps
- □ Joint Stiffness
- □ Muscle Pain

Endocrine:
- □ Excessive Thirst
- □ Fatigue
- □ Cold intolerance
- □ Heat intolerance

Cardiovascular:
- □ Chest Pain
- □ Heart Murmur
- □ High blood pressure
- □ Palpitations
- □ Varicos veins
- □ Rapid Heart Rate
- □ Irregular Heart Beat
- □ Heart Attack
- □ Rheumatic fever

Hema-Lymph:
- □ Anemia
- □ Blood Clotting
- □ Swollen glands
- □ Easy Bruising

Allergic/Immunologic:
- □ Drug Allergies
- □ Hay Fever

By signing below I am verifying that the information provided above is complete and accurate.

Signature:_____ **Date:** _____

PRECISION
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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

3Rd Edition: Developed by the Texas Pain Society, April2008 (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 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 for drugs and psychological evaluations if and 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 may result in my being discharged from your care.

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 its 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 judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

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 active 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 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.

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PAIN MANAGEMENT AGREEMENT:

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:

- My progress will be periodically reviewed and, if the medication(s) are not improving my 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 medications.
- 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, where 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.
- I understand that my medication(s) will be refilled on a regular basis. I 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 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 substance(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 specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- 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 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 the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

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 realize 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.**

_____
Patient Signature

_____
Physician Signature (or Appropriately Authorized Assistant)

_____
Name and contact information for pharmacy