Spine Care & Pain Management

Name, Last: _____ MI: _____ First: _____

Date of Birth: _____ Sex: _____M _____F Social Security #: _____

Home Address: _____ City/State/Zip: _____

Home #: _____ Cell #: _____ May we leave a voice message? _____Y _____N

Email Address: _____ **Preferred Method of Contact**: _____

Employer: _____ Occupation: _____

Employer Address: _____ Employer Phone #: _____

Current Primary Care Physician? _____Phone #: _____

PCP Address: _____ Marital Status: _____

Spouse's Information ***IF NOT MARRIED, THEN EMERGENCY CONTACT**

Name, Last: _____ MI: _____ First: _____

Date of Birth: _____ Social Security #: _____

Home Address: _____ City/State/Zip: _____

Home #: _____ Cell #: _____ Email Address: _____

Insurance Information

Insurance Carrier: _____ Policy #: _____

Policy Holder's Name: _____ Date of Birth: _____

Insurance Carrier: _____ Policy #: _____

Policy Holder's Name: _____ Date of Birth: _____

How did you hear about our practice? _____

Do we currently treat any of your family members? _____Yes _____No If so, their name(s)?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ DOB: _____

Previous Medical Providers

So that we may better evaluate your medical condition, we must have a complete record of your past medical history. Please list all of the medical providers you have seen for your pain so that we may request your records. We ask that this list be as complete as possible so that we may provide a proper treatment plan.

Doctor: _____ Address: _____

Phone #:_____ Fax (REQUIRED):_____

Doctor: _____ Address: _____

Phone #:_____ Fax (REQUIRED):_____

Doctor: _____ Address: _____

Phone #:_____ Fax (REQUIRED):_____

Doctor: _____ Address: _____

Phone #:_____ Fax (REQUIRED):_____

Consent to Release Confidential Information to Family Members/Friends

I, _____, give the physicians and office staff of Spine Care & Pain Management permission to discuss my medical condition and/or account information with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This consent is in force indefinitely unless revoked in writing by the patient.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Narcotic Agreement

By signing below I am acknowledging that I understand I will NOT be prescribed narcotics on my initial new patient visit with Spine Care & Pain Management. I understand that the initial consultation is an opportunity for me to meet the physician, share my history and symptoms, and discuss a detailed care plan.

Patient Signature: _____ Date: _____

Translation Services

Please acknowledge you will notify our office at least 72-business-hours in advance if you require translation services at any of your upcoming appointments with Spine Care & Pain Management. If we do not receive notification we will assume you do not require translation services or you will have an interpreter with you.

Patient Signature: _____ Date: _____

Por favor notifique a nuestra oficina por lo menos 72 horas antes de su próxima cita con Spine Care & Pain Management si necesita servicios de traducción. Si no recibimos notificación, vamos a suponer que usted no necesita servicios de traducción o usted traerá su proprio traductor.

Firma del paciente: _____ Date: _____

Notice of Privacy Practices (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from designated third-party payers.
Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Spine Care & Pain Management of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form or on the practice website at www.TameYourPain.com. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Signature: _____ Date: _____

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the United States Department of Health and Human Services. To file a complaint with our practice, please contact the Privacy Officer.
Contact Information
You may contact our Compliance Officer at 706-433-0954 or Info@TameYourPain.

Spine Care & Pain Management

Medical Questionnaire

Patient Name: _____ DOB: _____

1. Describe the events that caused your pain and the date it began:

_____

_____

_____

2. Have you had any other Medical Care since your last visit to your referring physician? (doctors, operations, therapy, ER, etc.): Yes ☐ No ☐

3. Are you or could you be pregnant? Yes ☐ No ☐

4. List **All Medications, dosages** you are currently taking and what they are for:

_____

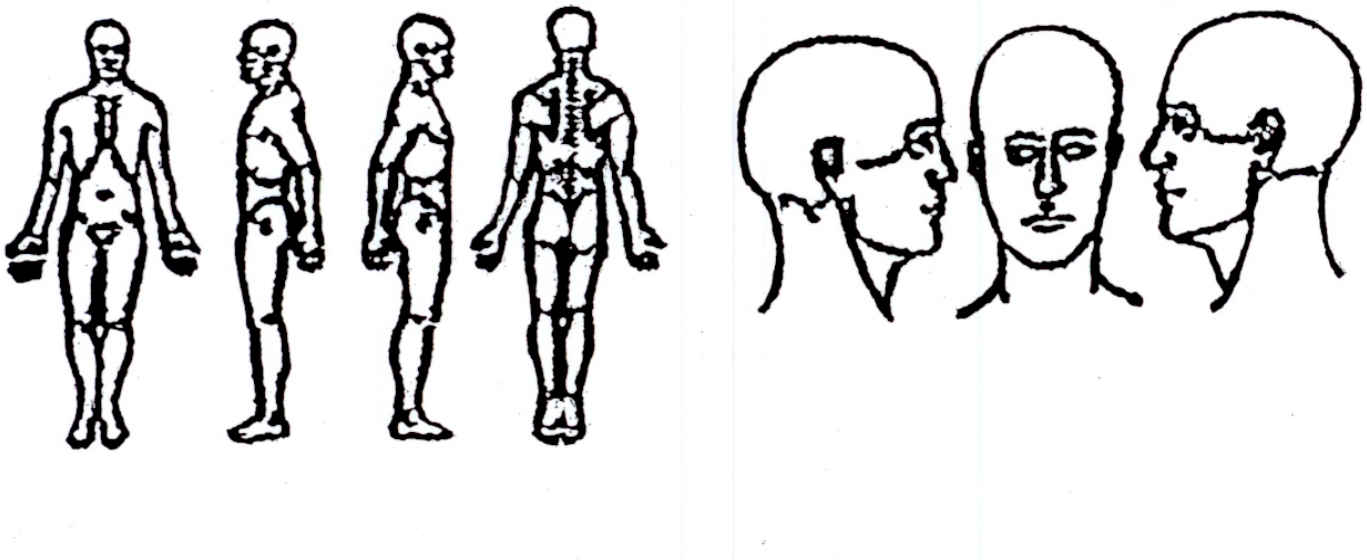
_____

_____

5. Please list the name and number of the one and only pharmacy you will use to fill your prescriptions:

_____

6. Shade in the areas where you feel pain**:**



I certify that the information given is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

What is your most painful area? _____

1. **Check ALL LOCATIONS of your PAIN**

☐ **Head** ☐ **Neck** **Shoulders** - ☐ Right ☐ Left **Arms/Hands** - ☐ Right ☐ Left
Back - ☐ Upper ☐ Lower **Legs** - ☐ Right ☐ Left **Feet** - ☐ Right ☐ Left

2. **How did your pain start (onset)?** ☐ Gradually ☐ Suddenly ☐ Work Injury ☐ Non-Work Injury ☐ Auto Accident
3. **How long have you had pain (duration)?** _____ Hours _____ Days _____ Weeks _____ Months _____Years
4. **Describe your pain.** ☐ Sharp ☐ Aching ☐ Stabbing ☐ Burning ☐ Shooting ☐ Throbbing ☐ Numbness ☐ Dull ☐ Electrical ☐ Tingling ☐ Clicking ☐ Night Pain ☐ Headaches ☐ Pins/Needles ☐ Spasms/Tightening
5. **When you move, do you have sharp, electrical shocking pain radiating into an extremity?** ☐ Yes ☐ No
   a. **If yes, how far down does it radiate?** **Arm** - ☐ Right ☐ Left **Fingers** - ☐ Right ☐ Left
   Leg - ☐ Right ☐ Left **Foot** - ☐ Right ☐ Left **Toes** - ☐ Right ☐ Left
6. **Do you have weakness in any limb?** ☐ Yes ☐ No
   a. **If yes, how far down does it radiate?** **Arm** - ☐ Right ☐ Left **Fingers** - ☐ Right ☐ Left
   Leg - ☐ Right ☐ Left **Foot** - ☐ Right ☐ Left **Toes** - ☐ Right ☐ Left
7. **Do you have numbness or tingling in any limb?** ☐ Yes ☐ No
   a. **If yes, how far down does it radiate?** **Arm** - ☐ Right ☐ Left **Fingers** - ☐ Right ☐ Left
   Leg - ☐ Right ☐ Left **Foot** - ☐ Right ☐ Left **Toes** - ☐ Right ☐ Left
8. **Your pain is aggravated by:** ☐ Nothing ☐ Sneezing ☐ Coughing ☐ Starting to Stool ☐ Bending ☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Everything ☐ Exercising ☐ Twisting ☐ Bright Light ☐ Medication ☐ Cold Exposure
9. **Your pain is relieved by:** ☐ Nothing ☐ Lying Down ☐ Resting ☐ Sitting ☐ Bending Forward ☐ Position Change ☐ Heat/Ice ☐ Massage ☐ Bracing ☐ Physical Therapy ☐ Dark Room ☐ Medication ☐ Standing ☐ Walking

Severity of your Pain is:	None ☐	Very Weak ☐	☐	Weak ☐	Moderate ☐	☐	Strong ☐	Intense ☐	Severe ☐	Excruciating ☐	Intolerable ☐
Average Pain Score in the last month	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Course of Pain	☐ Increasing	☐ Decreasing	☐ Recurring	☐ Without Change							

10. **Treatments tried:** ☐ Medication ☐ Physical Therapy ☐ Massage Therapy ☐ Facet Injection ☐ Nerve Block ☐ Psychotherapy ☐ Implanted Spinal Cord Stimulator ☐ Chiropractic ☐ Epidural Injection ☐ SI Joint Injection ☐ Nerve Ablation, RFTA ☐ Surgery with devices ☐ Surgery without devices
11. **On an average day, how many hours are up, moving about or active**? _____ Hours
12. **On an average night, how many TOTAL hours do you sleep?** _____ Hours
    a. Is your sleep broken at night? ☐ Yes ☐ No
    b. Do you feel rested in the morning? ☐ Yes ☐ No
13. **Any bowel or bladder leakage when sitting?** ☐ Yes ☐ No
14. **New or bothersome side effects include:** ☐ Bladder ☐ Concentration ☐ Dizziness ☐ Drowsiness ☐ Recent Falls ☐ Constipation ☐ Moodiness ☐ Dropping Things ☐ Itching

Patient Name: _____ DOB: _____

Social History

1. **Have you previously used illegal drugs?** ☐ Yes ☐ No
   - If yes, what type? _____
2. **Are you currently using illegal drugs?** ☐ Yes ☐ No
   - If yes, what type? _____
3. **Do you drink alcohol?** ☐ Yes ☐ No
   - If so how much/often? _____
4. **Do you consume caffeinated drinks?** ☐ Yes ☐ No
   - If yes, how many per day? _____
5. **Are you a smoker?** ☐ Yes ☐ No
   - If yes, how Long? _____ Packs/day? _____
6. **Are you currently employed?** ☐ Yes ☐ No
   - If so, what is your current occupation? _____
   - If not employed, what was your most recent occupation? _____
7. **Are you not working due to pain?** ☐ Yes ☐ No
8. **Are you receiving compensation for your disability?** ☐ Yes ☐ No
9. **Are you involved in litigation (lawsuit)?** ☐ Yes ☐ No
   - If so who is your attorney? _____
10. **If not employed do you plan to return to work?** ☐ Yes ☐ No
11. **Are you currently a student?** ☐ Yes ☐ No
12. **Highest level of education completed?** _____
13. **List family members who have physical or mental disabilities and describe disability.**

_____

_____

Patient Name: _____ DOB: _____

Yes	No	History of
		Arthritis
		Bleeding or Clotting
		Cancer
		Chest Pain
		Diabetes Mellitus
		Gastric Ulcer
		Headaches
		Heart Disease
		Hepatitis
		Hypertension
		Kidney Disease
		Neurological Disease
		Respiratory Disease
		Seizure Disorder
		Stroke
		Thyroid Disease
		Tuberculosis
		Other

Yes	No	Allergies
		No Known Allergies
		Aspirin
		Acetaminophen
		Antibiotics
		Iodine
		Latex
		Morphine Derivative
		NSAIDs
		Penicillin
		Peanuts
		Sulfa Drugs
		Seafood

Yes	No	Family History
		Alcohol Abuse
		Drug Abuse
		Cancer
		Diabetes Mellitus
		Heart Disease

Marital Status	
	Single
	Married
	Divorced
	Widowed
You Live With	
	Alone/Self
	Spouse
	Others

Do you have children?

☐ Yes ☐ No

If so, what are their ages?

_____

Surgeries

Date _____ What Type? _____

Location? _____ City/State _____

Date _____ What Type? _____

Location? _____ City/State _____

Date _____ What Type? _____

Location? _____ City/State _____

Hospitalizations

Date _____ Reason:_____ Location:_____

Date _____ Reason:_____ Location:_____

Date Reason: Location:

Radiology Studies

MRI: Date _____ Location: _____

EMG: Date _____ Location: _____

CT SCAN: Date _____ Location: _____

X-Ray: Date _____ Location: _____

Patient Name: _____ DOB: _____

Please indicate if you have any of the following:

General

Yes	No	Symptom
		Pain
		Medication Changes
		Weight Loss
		Significant Weight Change
		Weight Gain
		Chills
		Fever
		Night Sweats

Skin

Yes	No	Symptom
		Clamminess
		Excessive Sweating
		Hair Loss
		Pale Skin (Pallor)
		Rash
		Skin Color Changes

HEENT

Yes	No	Symptom
		Headache
		Visual Disturbances
		Decreased Hearing
		Ear Ringing (Tinnitus)
		Off Balance (Vertigo)
		Nasal Congestion
		Sore Throat
		Difficulty Chewing

Respiratory

Yes	No	Symptom
		Cough
		Difficulty Breathing
		Shortness of Breath (Dyspnea)

Breast

Yes	No	Symptom
		Breast Pain

Cardiovascular

Yes	No	Symptom
		Chest Pain
		Fainting/Blacking Out
		Edema (Swelling of extremities)
		Hypertension
		Orthopnea (Difficulty breathing while lying)
		Leg Pain or Swelling
		Shortness of Breath

Gastrointestinal

Yes	No	Symptom
		Abdominal Pain
		Constipation
		Diarrhea
		Nausea
		Vomiting

Male Genitourinary

Yes	No	Symptom
		Change in Urinary Stream
		Groin Pain
		Incontinence
		Testicular Pain
		Impotence

Female Genitourinary

Yes	No	Symptom
		Change in Urinary Stream
		Incontinence
		Menstrual Pain
		Pelvic Pain

Musculoskeletal

Yes	No	Symptom
		Back Pain
		Decreased Range of Motion
		Joint Pain
		Joint Stiffness
		Joint Swelling
		Muscle Atrophy/Wasting
		Muscle Cramps
		Leg Cramps
		Muscle Weakness
		Muscle Pain (Myalgia)
		Swelling of Extremities

Neurological

Yes	No	Symptom
		Auras-Migraine (Changes prior to Migraine)
		Decreased Memory
		Dizziness
		Fainting
		Falls
		Stool Incontinence
		Urinary Incontinence
		Numbness
		Seizures
		Vertigo
		Spinning Sensation
		Extremities Weakness

Psychiatric

Yes	No	Symptom
		Change in Sleep
		Depression
		Easily Irritated
		Suicidal Thoughts
		Hypersomnia – Excessive Sleep
		Insomnia – Reduced Sleep
		Inability to Concentrate
		Mood Changes
		Panic Attacks
		Suicidal Planning

Endocrine

Yes	No	Symptom
		Appetite Changes
		Excessive Thirst
		Excessive Urination
		Hair Changes
		Sexual Dysfunction

Hematology

Yes	No	Symptom
		Anemia
		Easy Bruising

Spine Care & Pain Management
Financial Policies & Disclosures

Patient Name: _____ DOB: _____

1. **PAYMENT METHODS**
   Payment is due at the time of service. We accept Cash, Checks, MasterCard, Discover Card, and Visa. We will file a claim with your insurance company after your co-payment has been paid for all office visits and procedures. Although it is our policy to verify your benefits, please understand that you are responsible for any services not covered by your insurance. Please ask our business office if you are uncertain about whether we participate with your insurance plan. If you are not covered by health insurance, you will be required to pay your bill in full at the time of service. If the patient is a minor, the legal guardian of the child is held responsible for the full payment.

2. **PAYMENT PLANS**
   We will attempt to work with you if you have an account balance, but please understand that **payment is due at the time of service**. If we cannot obtain your cooperation, we reserve the right to send your account to a national collection agency after 90 days past due.

3. **RETURNED CHECKS**
   There is a charge of $25.00 for any returned check, plus the amount of the check. We will not accept a check from anyone who has had a returned check with us in the past

4. **FORMS**
   We receive a large number of requests for forms to be completed. We charge a reasonable administrative fee for this service. The request must be made in writing, after which you will be quoted the fee. This sum must be paid in advance. Please note that there is a minimum of three business days required to complete any form.

5. **WAIT TIMES**
   Please note that on occasion you may experience an extended wait time due to situations beyond our control. Each patient on the schedule will be seen and given ample time with the provider. If the wait times become an inconvenience, please let us know so that we may reschedule your appointment.

6. **MISSED APPOINTMENTS OR "NO-SHOW" APPOINTMENTS**
   We ask that you call if you cannot make your scheduled appointment. If you do not call at least 24-hours in advance the following fees will be assessed to your account.
   $35.00 for a missed appointment, $100.00 for a missed procedure, $50.00 for a missed therapy appointment
   Please note: these amounts are due prior to being seen again.)
   If you fail to no show for 2 appointments we reserve the right to refuse scheduling or rescheduling of any appointments for you to be seen again. A no-show is defined as not showing for an appointment or canceling an appointment less than 24 hours before the scheduled time. This includes not showing for an appointment with your physician, physical therapist or massage therapist

7. **PROCEDURES**
   Spine Care & Pain Management, a Procedure Center may occupy the same building, but are completely separate businesses. Procedures performed in the surgery center are not performed "in the doctor's office". By having procedure at a Procedure Center, you will typically generate three separate bills. They are as follows:

   1. Facility
   2. Physician (Doctor who performed procedure)
   3. Anesthesia (Anesthesiologist's services if required)

I understand and agree to the financial policy as stated above.

Responsible Party Signature: _____ Date: _____

Spine Care & Pain Management

ASSIGNMENT OF MEDICAL HEALTH INSURANCE AND OTHER INSURANCE BENEFITS

Patient Name: _____ DOB: _____

Consent for treatment: I hereby give consent to Spine Care & Pain Management and their respective staff to perform medical procedures, which are appropriate for my condition, symptoms, illness(es) or injury(ies).

Assignment of insurance benefits and direct payment: I hereby assign to Spine Care & Pain Management the benefits of any and all insurance policies, including **Health Insurance** and **Personal Injury Protection (PIP)** to which I may be entitled. I hereby direct any and all insurance companies to make direct payment to Spine Care & Pain Management for all services, items and/or supplies furnished to me. I request that all payments to Spine Care & Pain Management be sent directly to the billing address.

Release of medical information and treatment records: I hereby authorize the release of any medical or psychological information necessary to submit, document or process insurance claims on my behalf.

Responsibility for payment: Except where prohibited by law, statute or regulation, I understand that I remain directly and personally responsible to Spine Care & Pain Management for all charges submitted by them which pertain to me and that nothing in this authorization and assignment shall be construed to waive my obligation to forward Spine Care & Pain Management payment from all or any portion of insurance payments received by me for health care services.

Waiver of statute of limitations: In consideration of courtesy and patience extended to me by Spine Care & Pain Management, I hereby agree that the statute of limitations with respect to any claim for charges for services by Spine Care & Pain Management shall not begin to run until there is a denial by me, in writing and sent by certified mail with return receipt requests, of any balance claimed to be due and owing Spine Care & Pain Management.

Assignment of cause or action: In the event that any insurance company which is obligated by contract, statute, or law to make a payment to me or to Spine Care & Pain Management for professional services refuses to make such payment upon demand by Spine Care & Pain Management, I hereby assign and transfer to Spine Care & Pain Management to prosecute any such action in my name and/or their name to compromise, settle, or otherwise resolve said claim as they see fit. This assignment may be revoked only in writing by me and only if such revocation is sent by certified mail, upon receipt, to Spine Care & Pain Management. A photocopy of this assignment and authorization shall be binding as an original.

I acknowledge that I have read, understand and agree with the **Notice of Privacy Practices** and **Assignment of Medical Health Insurance and other insurance benefits,** which have been made available to me by Spine Care & Pain Management.

Patient Signature: _____ Date: _____

Spine Care & Pain Management

Medical Information Release Form

1. I, _____, authorize _____
(Patient's name) (***Previous*** provider's name)

To release records to:

☐ Spine Care & Pain Management
18 Riverbend Drive, Suite 120
Rome, GA 30161
Phone #: 706.378.1202
Fax#: 1.855.269.0487

☐ Spine Care & Pain Management
1560 Kingsley Ave., Suite 3
Orange Park, FL 32073
Phone #: 904-458-7246
Fax#: 904-517-5072

2. **INFORMATION TO BE RELEASED:**

☑ All medical records, which includes the following:
Office/ER Notes
Procedure Notes
Lab Work (UDS reports)
Current Medication list
All Imaging Reports
Demographic and Insurance Information
Discharge Letter (if applies)

3. ☐ **RECORDS FROM THE TIME PERIOD:** _____/_____/_____ through _____/_____/_____

4. **PURPOSE OF DISCLOSURE:** (Check applicable purpose) ☐ ***Continued Medical Care***

☐ Payment of Insurance ☐ Personal ☐ Workers' Compensation Claim ☐Other: _____

5. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

6. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

7. The requestor may be provided with a copy of this authorization.

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below:
By signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases

☐ AIDS/HIV

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Name: _____SSN: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Patient Signature: _____ Date: _____

Spine Care & Pain Management
Compliance with Care Agreement

Patient Name: _____ DOB: _____

We at Spine Care & Pain Management understand that your pain is a significant hindrance to the quality of life you desire. In order to help you achieve your goals, we may recommend different medicines, selective diagnostic and therapeutic nerve blocks, physical and occupational therapy, therapeutic massage, and psychological counseling, as needed.

Narcotic medication for pain will NOT be prescribed on your first visit. This type of medication is solely given based on the medical findings and treatment plan of a Spine Care & Pain Management physician and not doctors you may have visited previously. Although narcotics have a long history of safety, there are possible side effects. Therefore we must weigh the risks versus benefits before prescribing these medications. ***If*** we decide to use these medicines, the following conditions must be met:

Please read each item carefully then initial in the spaces indicated, acknowledging your understanding of each item.

_____ 1. If deemed necessary, we will require a consult from a psychologist.

_____ 2. Additional therapy may be recommended for which you are required to participate.

_____ 3. You must maintain the medication-dosing schedule prescribed by the doctors from this clinic. You may not increase the dose on your own. You must come in and discuss any changes before they are made. If you take your medication in any way other than prescribed, it will not be refilled.

_____ 4. You must notify this office first, before you receive/take narcotics from any other clinic, doctor, or hospital.

_____ 5. You must have your narcotic prescriptions filled at only one pharmacy and must have the pharmacy name and number on file at this office. Narcotics cannot be called in for any reason.

_____ 6. Narcotic prescriptions can only be given to the patient. They cannot be mailed or picked up by someone else.

_____ 7. Narcotic prescriptions may not be replaced if lost or stolen or for any other reason, even with a police report.

_____ 8. If a medicine is not working for you and you would like it changed, please call to make an appointment for a medication change evaluation and bring in the unused portion of medication. Unused narcotics must be destroyed in our office.

_____9. You will be required to undergo random urine drug screen testing and random pill counts. If so, you will be contacted by telephone. It is your responsibility to provide a telephone number where you can be contacted during regular business hours 8 – 5 M-F. If you cannot answer your telephone personally, you are responsible for having a voicemail or other method of receiving the telephoned message that day. If you fail to come in for a drug screen or pill count on the day you are called you will be discharged from the clinic.

_____ 10. You are required to inform our office of your out-of-town travel, prior to your departure. You will call the office and inform a staff person of your name and the dates of your travel. If you are called for a random pill count or urine drug screen and fail to show saying you were out of town, but do NOT have the trip noted in your chart, your provider reserves the right to discontinue your medication.

Compliance with Care Agreement, pg. 2

_____ 11. You must not take any illegal drugs or medications prescribed to someone other than you. You must not give any medications prescribed to you to another person. You must avoid drinking alcohol, if you are taking a narcotic medication for pain control. Contact your physician before taking sedatives, antihistamines or Benzodiazepines. Some examples include but are not limited to: Soma, Xanax, Ativan or Benadryl.

_____ 12. By signing this agreement you give this office permission to request information about your narcotic prescriptions from other medical offices or pharmacies.

_____ 13. By signing this agreement you give us permission to share your narcotic prescription history with other pharmacies, physician offices, or law enforcement agencies.

_____ 14. Weekly visits may be required to monitor your condition when narcotics are initially prescribed or after a change in medications. If the above conditions are broken, we reserve the right to dismiss you from our care.

_____ 15. Side effects. You understand that controlled substances may cause a variety of side effects, including, but not limited to: nausea, vomiting, constipation, dry mouth, difficulty with urination, urinary retention, confusion, weight changes, suppressed immune system, altered hormone levels (thyroid, sexual hormones), itching, allergic reactions, fluid and blood chemistry imbalances, and altered sexual function. There is also a risk of becoming physically dependent or addicted. Therefore, I understand if that taken improperly, controlled substances may cause excess sedation, depressed breathing and even death, especially if combined with alcohol, Benzodiazepines (Xanax, Valium, Ativan etc.) or other mood or consciousness-altering substances. You understand that you may not drive a motor vehicle or other heavy machinery while taking narcotics, and you will comply with all state and federal laws regarding such activities while using these medications.

_____ 16. You understand that your medications should be kept up and out of the way or locked up from children or irresponsible adults.

_____ 17. You understand that it is unlawful for any person to withhold information from a practitioner that such person has obtained a controlled substance of similar therapeutic use in a concurrent time period from another practitioner.

Patient Signature: _____ Date: _____

Physicians Signature: _____

Patient Name: _____ DOB: _____