DFW LASER SPINE INSTITUTE

972-884-4400

www.DFWSpineInstitute.com
10400 N Central Expressway, Dallas, TX
75231

NEW PATIENT INTAKE FORM

Please PRINT and complete ALL sections

Is your condition the result of a: Work injury? ☐ YES ☐ NO Auto accident? ☐ YES ☐ NO Date of Injury: ___/___/____

PATIENT INFORMATION

Name: _____ _____ _____
First MI Last

Street Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

E-mail address: _____

Home Phone: (_____ Work Phone: (_____ Mobile Phone: (_____

Date of Birth: _____ / _____ / _____ Age: _____ Driver's License: _____ / _____ Social Security No.: _____ / _____ / _____
Mo. Day Year State Lic. #

Employer Name: _____ Occupation: _____ ☐Full Time ☐Part Time

Employer Address: _____ Employer Phone: ( ) _____ _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ _____ _____ Spouse DOB: _____ , _____ , _____
First MI Last Mo. Day Year

Spouse's Social Security No.: _____ / _____ / _____ Spouse's Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____

Street Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ _____ Work Phone: ( ) _____ _____ Mobile Phone: ( ) _____ _____

REFERRAL INFORMATION

*** Important! This information allows us to keep your physicians updated regarding your spine care.**

Referring Physician Name, Address and Phone: _____

_____ _____

PCP Name and Address (if different from referring physician): _____

☐ Website, or internet search engine; If so, which one? _____

☐ Magazine; If so, which one? _____

☐ Newspaper ☐ Seminar ☐ TV ☐ Phone Book ☐ Direct Mailing ☐ Billboard ☐ Self

☐ Family, Who may we thank for your referral _____ _____

☐ Friend, Who may we thank for your referral _____ _____

☐ Other _____

INSURANCE INFORMATION

PRIMARY Insurance Company: _____ Insurance Address: _____

Insurance ID #: _____ Group #: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ DOB: _____ / _____ / _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____ Insured Social Security No.: _____ / _____ / _____

Patient Name:_____ DOB ___ ___ _____

SECONDARY Insurance Company: _____ Insurance Address:_____

Insurance ID #: _____ Group #:_____ City: _____ State: _____ Zip: _____

Name of Insured: _____ DOB: _____ / _____ / _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____ Insured Social Security No.: _____ / _____ / _____

PREFERRED PHARMACY

Name: _____ Phone Number: (_____ _____

Please note that some pain medications cannot be filled through a mail order pharmacy AND some prescriptions may not be called in to your pharmacy due to FEDERAL REGULATIONS. Please provide the name of your preferred pharmacy.

CONSENT FOR TREATMENT

I understand that I have presented myself to the Minimally Invasive Surgery Institute for evaluation and/or treatment for my condition. I authorize and direct the physicians, nurse practitioners and necessary assistants of MISI to perform quality care upon me, and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

_____
(Initial)

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

Method of Payment: ☐ Cash ☐ Credit Card ☐ Check

I hereby designate Minimally Invasive Surgery Institute as my healthcare provider and as such I give authorization for payment of insurance benefits to be made directly to MISI Associates DBA the Minimally Invasive Surgery Institute (MISI) and any assisting physicians for services rendered. **I understand that I am financially responsible for all charges whether or not they are covered by my insurance.** In the event of default, I agree to pay all costs of collection. I further agree that a photocopy of this agreement shall be as valid as the original. **I acknowledge that I am responsible for and agree to pay my annual deductible balance, coinsurance payment amount, and any non-covered services charges at the time of my visit.**

_____
(Initial)

I authorize Minimally Invasive Surgery Institute and their billing companies, to negotiate, discuss and in any other way communicate with my insurance company in those areas relative to OON reimbursements, methodology used in OON negotiation and a fair negotiation of final payment. I authorize Minimally Invasive Surgery Institute and its billing company to accept or reject agreements, to enter into contracts binding upon final adjudication of claims and negotiations, and to act in whatever way necessary so as to accomplish that which is being undertaken. _____
(Initial)

ERISA PLANS

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. _____
(Initial)

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

I understand that my provider has financial interest in the Ancillary Services and the Ambulatory Surgical Center (ASC), to which I may be referred. Ancillary services include: pharmacy, laboratory, DME, neuro-monitoring, anesthesia, orthopedic supply companies, etc. My provider has recommended that I use these Ancillary Services or ASC based on his professional judgment and not because he has such financial interests.
My provider will gladly discuss this recommendation with me and will provide me with alternatives to the Ancillary Services or the ASC, at my request.

_____
(Initial)

MISI FACSIMILE AND ELECTRONIC DATA TRANMISSION AUTHORIZATION

I, the undersigned, authorize MISI to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) AND by the Texas House bill 300 by facsimile or electronic transmission to myself, healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving MISI five (5) days written notice. **This revocation may be by facsimile transmission; however, a written copy of the revocation must be mailed within 15 days to Minimally Invasive Surgery Institute as well.**

(Initial)

HIPPA ACKNOWLEDGEMENT

I have received and reviewed the Notice of Privacy Practices.

_____
(Initial)

CONTACT AUTHORIZATION

Check where you can be reached during business hours: ☐ Home ☐ Work ☐ Mobile

May we contact you at home? ☐ Yes ☐ No
Leave message with: _
Voicemail / Answering Machine: ☐ Yes ☐ No
Mobile Phone: ☐ Yes ☐ No
Family Member: ☐ Yes ☐ No

May we contact you at work? ☐ Yes ☐ No
Leave message with: _
Voicemail / Answering Machine: ☐ Yes ☐ No
Mobile Phone: ☐ Yes ☐ No
Co-worker: ☐ Yes ☐ No

May we contact you by email? ☐ Yes ☐ No If yes, email address: _

I hereby give permission to the Minimally Invasive Surgery Institute to disclose and discuss any information related to my medical conditions to/with the following (Primary Care Physician, Treating Physician, Case Worker, Adjustor)

Name: _ Relationship: _

Name: _ Relationship: _

I hereby give permission to the Minimally Invasive Surgery Institute to disclose and discuss any information related to my medical conditions to/with the following (relatives, or close personal friends):

Name: _ Relationship: _

Name: _ Relationship: _

OR

_____ 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

EMERGENCY CONTACT/ LEGAL GUARDIAN

Name: _ Relation: _ Phone #: _

Address: _

This release will remain in effect until revoked by me in writing.

Patient Name (PRINTED): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PAIN DIAGRAM

Is your condition the result of a: Work injury? ☐ YES ☐ NO Auto accident? ☐ YES ☐ NO Date of Injury: _____

FOR SPINE PATIENTS:

Please indicate in table below the percentage of pain you currently feel in your neck, arm, back and legs. Example (0%, 25%, 75%, 100%)

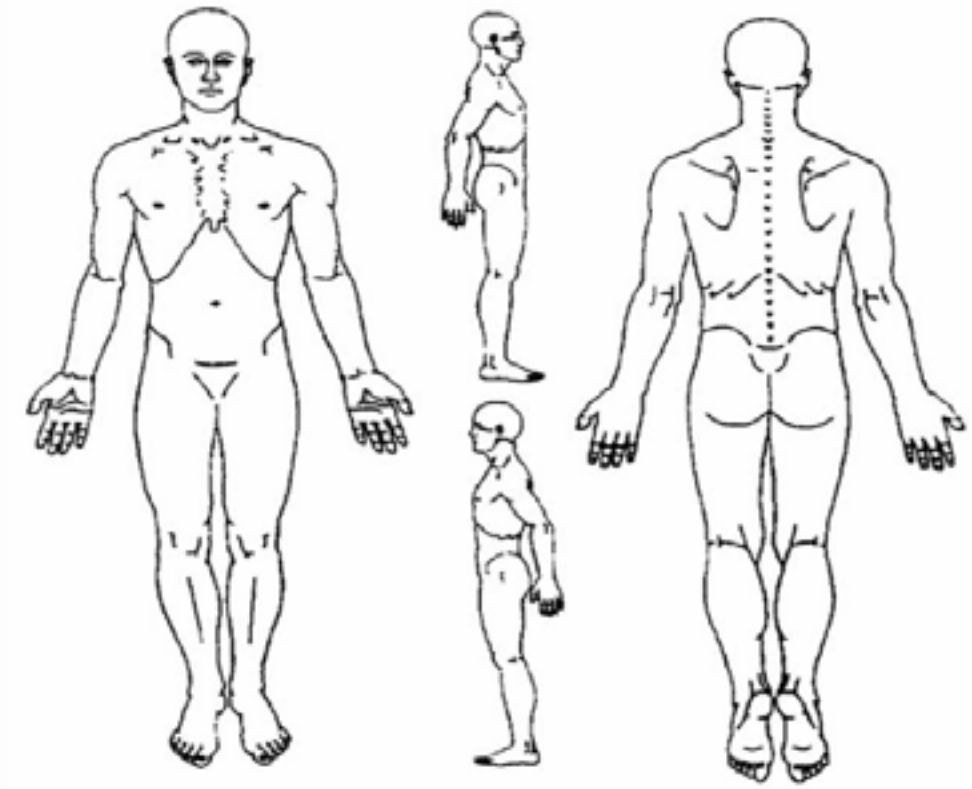
* Total of percentages should equal 100%.

For patients with neck and arm pain		For patients with back and leg pain	
Neck Pain	_____ %	Back Pain	_____ %
Arm Pain	_____ %	Leg Pain	_____ %
Total Pain	100%	Total Pain	100%

FOR ALL PATIENTS:

Please mark the area of discomfort on the diagram below using the appropriate symbols:

Pain or burning: **x x x x x**
Numbness: **o o o o o**
Pins and Needles: **= = = = =**



Grade your overall pain.Circle your number below:

Please place an X on the hash mark that most accurately describes your overall degree of pain *now.*

HISTORY (Check all that apply):

Chief Complaint: ☐ Back pain Leg: ☐ Pain ☐ Numbness/Tingling ☐ Weakness ☐ Other Body Part (specify)_____

☐ Neck pain Arm: ☐ Pain ☐ Numbness/Tingling ☐ Weakness ☐ Balance Deficit ☐ Gait Instability

☐ Headaches ☐ Hand/Finger/ Wrist Pain ☐ Numbness/Tingling ☐ Weakness ☐ Foot/Toe/Ankle Pain ☐ Gait Instability

How did you get hurt? (Circle one) Insidious Onset / Other: _____

How long has the pain (or your problem) been present?

☐ Date of Injury? _____ OR: ☐ Less than 6 months ☐ More than 6 months ☐ Greater than 1 year

My pain is ☐ Worsening ☐ Improving ☐ Unchanged since it started

For patients with NECK or ARM pain, numbness or weakness:

Neck Pain ☐ R ☐ L Arm Pain ☐ R ☐ L

Numbness ☐ R ☐ L Weakness ☐ R ☐ L

For patients with BACK or LEG pain, numbness or weakness:

Back Pain ☐ R ☐ L Leg Pain ☐ R ☐ L

Numbness ☐ R ☐ L Weakness ☐ R ☐ L

Do you have difficulty picking up small objects like coins or buttoning buttons? ☐ YES ☐ NO

Do you have problems with balance or frequent tripping? ☐ YES ☐ NO

Worst position for pain is: ☐ Sitting ☐ Standing ☐ Walking

How many minutes can you stand/walk before you need to rest? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

Lying down: ☐ Eases the pain ☐ Does not ease the pain ☐ Sometimes eases the pain

Bending forward: ☐ Increases the pain ☐ Decreases the pain ☐ Does not affect the pain

Pain is: ☐ Worse at night ☐ Wakes you up

There is: ☐ No loss of bowel or bladder control (incontinence) ☐ Loss of bowel and bladder control since: _____

Other activities/positions that **increase** pain: _____

Other activities/positions that **reduce** pain: _____

I have: ☐ Not missed any work because of this problem ☐ How much work have you missed: _____

What words describe the quality of your pain: ☐Sharp ☐Stabbing ☐ Shooting ☐ Electric ☐Burning ☐ Aching ☐Throbbing ☐ Numbing

Treatment has included: ☐ NO medication, physical therapy, chiropractic manipulations, injections, or bracing

☐ Anti-inflammatory medication	☐ Chiropractic manipulation	☐ Medication Pump	☐ Biofeedback
☐ Muscle relaxants	☐ Acupuncture	☐ Spinal Cord Stimulator	☐ Traction
☐ Narcotic pain medication	☐ Nerve Blocks	☐ Braces	☐ Massage
☐ Physical Therapy	☐ In-office injections without	☐ X-ray	☐ Sacroiliac (SI) Injections
☐ Relaxation Training	☐ Epidural steroid injections	☐ Acupuncture	
☐ TENS Unit	☐ Facet injections	Other:_	

PREVIOUS IMAGING STUDIES

What imaging studies have you had done? Please check all that apply:

☐ X-Rays ☐ CT Scan ☐ MRI ☐ Myelogram ☐ EMG ☐ Bone Scan Results: _____

PAST MEDICAL HISTORY Check all that apply: ☐ **None apply**

☐ Finger, hand or wrist pain	☐ Foot or ankle problems	☐ Headaches	☐ Stomach ulcers	☐ Other: _____
☐ Rheumatoid arthritis	☐ Lung disease	☐ High blood pressure	☐ Fibromyalgia	☐ Cancer
☐ Ankylosing spondylitis	☐ Liver disease	☐ Seizures	☐ Tuberculosis	☐ Serious injury (explain):
☐ Osteoarthritis	☐ Heart failure (CHF)	☐ Gout	☐ Heart attack	☐ Heartburn / Acid Reflux
☐ Bleeding disorders	☐ Stroke	☐ Thyroid issues	☐ Kidney stones	☐ Weight Management issues
☐ Blood clot in: leg/lung	☐ HIV/AIDS	☐ Diabetes	☐ Asthma	
☐ Osteoporosis	☐ Hepatitis	☐ Mental illness	☐ Anemia	☐ Last Colonoscopy on: _____
			☐ Kidney issues	

Patient Name: _____ DOB ___.___.____

COMPLETE SURGICAL HISTORY

Previous doctors seen for this problem: □ **NONE**

Doctor	Specialty	City	Treatment

MEDICATIONS

List pain medications and dose taken for *your current problem*: □ **NONE**

Please list ALL CURRENT medications and doses □ **None**

ALLERGIES

Please list any known allergies to food or medications and their reactions: □ **None**

REVIEW OF SYSTEMS

Are you currently or have had problems with: *** Please explain and describe all YES answers below**

Hematological / Bleeding problems	☐ Yes	☐ No	Describe:
Reproductive / Sexual problems	☐ Yes	☐ No	Describe:
Unexplained gain / weight loss:	☐ Yes	☐ No	Describe:
Skin:	☐ Yes	☐ No	Describe:
Ear, Nose, Throat:	☐ Yes	☐ No	Describe:
Stomach / Digestion / Abdominal pain:	☐ Yes	☐ No	Describe:
Bladder / Bowel problems:	☐ Yes	☐ No	Describe:
Musculoskeletal:	☐ Yes	☐ No	Describe:
Neurological:	☐ Yes	☐ No	Describe:
Psychiatric problems:	☐ Yes	☐ No	Describe:
Fever / Chills:	☐ Yes	☐ No	Describe:
Night sweats:	☐ Yes	☐ No	Describe:
Night pain / Pain at rest:	☐ Yes	☐ No	Describe:
Hernia:	☐ Yes	☐ No	Describe:
Gallstones	☐ Yes	☐ No	Describe:

FAMILY HISTORY

Check all that apply: ☐ **None apply**

☐ Stroke ☐ Alcoholism ☐ Kidney trouble or stones ☐ Seizures ☐Bleeding disorders

☐ Arthritis ☐ Heart trouble ☐ Cancer ☐ Diabetes ☐Other: _____

☐ Gout ☐ Mental illness ☐ High blood pressure ☐ Spine problems

SOCIAL HISTORY

Age: _____ years Sex: □ Male □ Female Height: _____ Wt: _____ Occupation: _____

Work Status: □ Homemaker □ Retired □ Disabled □ On leave □ Unemployed □ Employed: □ Full time □ Part time

Marital Status: □ Married □ Single □ Divorced □ Widowed Number of living children: _____ □ None

I live: □ Alone □ With: _____

Do you smoke? □ Yes □ No _____ packs/day for _____ years
□ Quit How long ago? _____

Drink alcohol? □ Daily □ 1-2 x/week □ 1-2 x/month □ Never
□ Alcoholic □ Recovering alcoholic

Illicit drug use: □ Never □ Currently □ In the past

Because of this current injury, I have filed or plan to file: □ A lawsuit □ A Worker's Compensation claim □ Neither

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.

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 will supply my pharmacy's name and phone number.
- 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 addictionology's 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.

Patient Name: _____ DOB ___.___.____

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.**

Pharmacy contact information: _____
(Business name)

Pharmacy Phone number: _____

Pharmacy Fax Number: _____

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

_____
Physician's Printed Name (or Appropriately Authorized Assistant)

_____ _____
Physician's Signature (or Appropriately Authorized Assistant) Date