memorialorthopedicsurgery
MEMORIAL HEALTH

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Name: (Last)_____ (First)_____ (MI)_____

Address: _____

City, State, Zip: _____

Home:_____ Cell: _____ Work: _____

E-Mail Address: _____ DOB:_____

Sex: ○ Female ○ Male ○ Transgender

Race: ○ American Indian/Alaska Native ○ Asian ○ Hispanic ○ Native Hawaiian/Pacific Islander ○ Black/African American ○ White ○ Other ○ Declined

Language: ○ English ○ Spanish ○ Indian: Hindi, etc. ○ Japanese ○ Chinese ○ Korean ○ French ○ German ○ Russian ○ Other Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Declined

Social Security Number: _____-_____-_____

RESPONSIBLE PARTY INFORMATION *(if not self)* (Information used for patient balance statements)

Responsible party: ○ Another patient ○ Guarantor ○ Self

Check here if address and telephone information is same as patient ☐ Responsible party name:

(Last)_____ (First)_____ (MI)_____

Date of birth: MM_____/ DD_____/YYYY_____ Sex: ○ Female ○ Male

Social Security Number: _____-_____-_____ Phone Number: _____

Address: _____

City, State: _____ Zip: _____

Employer Information	
Name of Employer	
Employer Address	
Employer Phone Number	

Health Insurance	
Primary Insurance Name	
Primary Insurance Address	
Primary Insurance Phone Number	
Primary Insurance Policyholder	
Primary Subscriber Number	
Primary Group Number	
Secondary Insurance Company	
Secondary Subscriber Number	
Secondary Group Number	

Pharmacy Information	
Pharmacy Name	
Pharmacy Address	
Pharmacy Phone Number	

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First)_____

Phone number: _____ Do you have a living will? ○ Yes ○ No

Emergency contact relationship to patient: _____ ☐ Guardian

Address: _____

City, State: _____ Zip: _____

Home phone: _____ Work phone: _____ Ext.: _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

Print Witness Name: _____ Date: _____

Witness Signature: _____ Date: _____

Is the reason for your visit today Workers' Comp? ○ Yes ○ No

Is the reason for your visit today an Auto Accident? ○ Yes ○ No

If Yes, please provide the insurance information.

Insurance Carrier Name: _____

Claim Number: _____

Claim Address: _____

Date of Accident: _____

Adjustor's Name/Phone #: _____

Patient Signature: _____ Date: _____

If this is an Auto Accident and you have a Letter of Protection, Memorial Orthopedic Surgery and Sports Medicine does not accept Letters of Protection. The patient would be responsible for payment after auto is exhausted.

I, _____ certify that I have read and understand the above statement.

PATIENT CONSENT FORM

Please Read and Sign

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intent this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Memorial Orthopedic Surgery and Sports Medicine** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Memorial Orthopedic Surgery and Sports Medicine** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Memorial Neurospine Center.

I acknowledge that I have been given **Memorial Orthopedic Surgery and Sports Medicine** Notice of Privacy Practices. I understand that if I have questions or complaint that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature: _____ Date: _____

PATIENT FINANCIAL AGREEMENT

PATIENT NAME: _____ DATE OF BIRTH: _____

1. _____ (Patient or Guardian Initials)
   Financial Agreement.
   - I acknowledge that as a courtesy, **Memorial Orthopedic Surgery and Sports Medicine** may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
   - I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)
   Third Party Collection. I acknowledge that **Memorial Orthopedic Surgery and Sports Medicine** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Services") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)
   Assignment of Benefits. I hereby assign to **Memorial Orthopedic Surgery and Sports Medicine** any insurance or other third-party benefits available for health care services provided to me. I understand **Memorial Orthopedic Surgery and Sports Medicine** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Memorial Orthopedic Surgery and Sports Medicine**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)
   Medicare Patient Certification and Assignment of Benefits. I certify that any information I provide, if any, in applying for payment under Title XVII ("Medicare") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Memorial Orthopedic Surgery and Sports Medicine** by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)
   Consent to Telephone Calls for Financial Communications. I agree that in order for **Memorial Orthopedic Surgery and Sports Medicine**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Memorial Orthopedic Surgery and Sports Medicine** or EBO Services and collection agents may contact me by telephone at any telephone number, without limitation or wireless, I have provided **Memorial Orthopedic Surgery and Sports Medicine** or EBO Services and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)
   A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____ Date: _____

If you are not the Patient, please identify your Relationship to the Patient.

(Check relationship(s) from list below):

○ Spouse ○ Parent ○ Legal Guardian ○ Guarantor ○ Power of Attorney

○ Other: _____

HCA PHYSICIAN SERVICES
MEMORIAL ORTHOPEDIC SURGERY AND SPORTS MEDICINE
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:	**Birth Date:**	**Patient 's Phone:**	**Last Four Digits SSN *(optional)*:**

Provider's Name:	**Recipient's Name:**		
Memorial Orthopedic Surgery and Sports Medicine			
Provider's Address:	**Address 1:**		
3627 University Blvd. S, Suite 500 Jacksonville, FL 32216	**Address 2:**	**Recipient's Phone:**	**Recipient's Fax:**
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided):
☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical Test ☐ Medication Sheets		☐ Operative Information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer forms ☐ ER Information		☐ Labor/delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill/billing statements ☐ UB-92: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

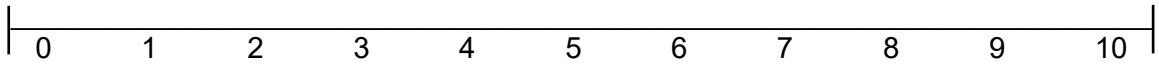
Photo ID Verified: _____

Memorial Orthopedic Surgery and Sports Medicine

MEDICAL HISTORY FORM

Patient: _____ Date: _____

Rate your pain on a scale of 0 to 10, with 0 being no pain and 10 the most severe pain. Please use an X.



Medical History

Patient Medical History

Diabetes	○ Yes	○ No	Previous other Surgeries / Serious Injuries When?
Hypertension	○ Yes	○ No	_____
Cancer	○ Yes	○ No	_____
Stroke	○ Yes	○ No	_____
Heart trouble	○ Yes	○ No	_____
Arthritis/gout	○ Yes	○ No	
Convulsions	○ Yes	○ No	
Bleeding tendency	○ Yes	○ No	
Acute infections	○ Yes	○ No	
Venereal disease	○ Yes	○ No	
Hereditary defects	○ Yes	○ No	

Patient Social History

Marital status:	○ Single	○ Married	○ Separated	○ Divorced	○ Widowed
Use of alcohol:	○ Never	○ Rarely	○ Moderate	○ Daily	
Use of tobacco:	○ Never	○ Previously, but quit	Current packs/day: _____		

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Memorial Orthopedic Surgery and Sports Medicine

Patient: _____ Date: _____

System Review:				
CONSTITUTIONAL SYMPTOMS			**MUSCULOSKELETAL**	
Good general health lately	○ Yes ○ No		Joint pain	○ Yes ○ No
Recent weight change	○ Yes ○ No		Joint stiffness or swelling	○ Yes ○ No
Fever	○ Yes ○ No		Weakness of muscles or joints	○ Yes ○ No
Fatigue	○ Yes ○ No		Muscle pain or cramps	○ Yes ○ No
Headaches	○ Yes ○ No		Back pain	○ Yes ○ No
EYES			Cold extremities	○ Yes ○ No
Eye disease or injury	○ Yes ○ No		Difficulty in walking	○ Yes ○ No
Wear glasses / contact lens	○ Yes ○ No		**INTEGUMENTARY (skin, breast)**	
Blurred or double vision	○ Yes ○ No		Rash or itching	○ Yes ○ No
Glaucoma	○ Yes ○ No		Change in skin color	○ Yes ○ No
EARS / NOSE / MOUTH / THROAT	○ Yes ○ No		Change in hair or nails	○ Yes ○ No
Hearing loss or ringing	○ Yes ○ No		Varicose Veins	○ Yes ○ No
Earaches or draining	○ Yes ○ No		Breast pain	○ Yes ○ No
Chronic sinus problems or rhinitis	○ Yes ○ No		Breast discharge	○ Yes ○ No
Nose bleeds	○ Yes ○ No		**NEUROLOGICAL**	
Mouth sores	○ Yes ○ No		Frequent or recurring headaches	○ Yes ○ No
Bleeding gums	○ Yes ○ No		Light headed or dizzy	○ Yes ○ No
Bad breath or bad taste	○ Yes ○ No		Convulsions or seizures	○ Yes ○ No
Sore throat or voice change	○ Yes ○ No		Numbness or tingling sensations	○ Yes ○ No
Swollen glands in neck	○ Yes ○ No		Tremors	○ Yes ○ No
CARDIOVASCULAR	○ Yes ○ No		Paralysis	○ Yes ○ No
Heart trouble	○ Yes ○ No		Stroke	○ Yes ○ No
Chest pain or angina pectoris	○ Yes ○ No		Head injury	○ Yes ○ No
Palpitation	○ Yes ○ No		**PSYCHIATRIC**	
Shortness of breath with walking or lying flat	○ Yes ○ No		Memory loss or confusion	○ Yes ○ No
Swelling of feet, ankles or hands	○ Yes ○ No		Nervousness	○ Yes ○ No
RESPIRATORY			Depression	○ Yes ○ No
Chronic or frequent coughs	○ Yes ○ No		Insomnia	○ Yes ○ No
Spitting up blood	○ Yes ○ No		**ENDOCRINE**	
Shortness of breath	○ Yes ○ No		Glandular or hormone problem	○ Yes ○ No
Asthma or wheezing	○ Yes ○ No		Thyroid disease	○ Yes ○ No
GASTROINTESTINAL			Diabetes	○ Yes ○ No
Loss of appetite	○ Yes ○ No		Excessive thirst or urination	○ Yes ○ No
Change in bowel movements	○ Yes ○ No		Heat or cold intolerance	○ Yes ○ No
Nausea or vomiting	○ Yes ○ No		Skin becoming dryer	○ Yes ○ No
Frequent diarrhea	○ Yes ○ No		Change in hat or glove size	○ Yes ○ No
Painful bowel movement or constipation	○ Yes ○ No		**HEMATOLOGIC / LYMPHATIC**	
Rectal bleeding or blood in stool	○ Yes ○ No		Slow to heal after cuts	○ Yes ○ No
Abdominal pain or heartburn	○ Yes ○ No		Bleeding or bruising tendency	○ Yes ○ No
Peptic ulcer (stomach or duodenal)	○ Yes ○ No		Anemia	○ Yes ○ No
GENITOURINARY	○ Yes ○ No		Phlebitis	○ Yes ○ No
Frequent urination	○ Yes ○ No		Past transfusion	○ Yes ○ No
Burning or painful urination	○ Yes ○ No		Enlarged glands	○ Yes ○ No
Blood in urine	○ Yes ○ No		**ALLERGIC / IMMUNOLOGIC**	
Change in force of strain when urinating	○ Yes ○ No		History of skin reaction or other adverse reaction to:	
Incontinence or dribbling	○ Yes ○ No		Penicillin or other antibiotic	○ Yes ○ No
Kidney stones	○ Yes ○ No		Morphine, Demerol, or other narcotics	○ Yes ○ No
Sexual difficulty	○ Yes ○ No		Novocain or other anesthetics	○ Yes ○ No
Male – testicle pain	○ Yes ○ No		Aspirin or other pain remedies	○ Yes ○ No
Female – pain with periods	○ Yes ○ No		Tetanus antitoxin or other serums	○ Yes ○ No
Female – irregular periods	○ Yes ○ No		Iodine methiolate or other antiseptics	○ Yes ○ No
Female – vaginal bleeding	○ Yes ○ No		Other drugs / medications _____	
Female - # of pregnancies _____ # of miscarriages _____			Known food allergies _____	
Female – date of last pap smear _____				

Memorial Orthopedic Surgery and Sports Medicine

Patient: _____ Date: _____

Current Medications - both prescription and OTC (over-the-counter):

Medication Name	Dosage	Frequency

Medication Allergies: _____

Special Questions: (Indicate Yes or No)

Change in Handwriting _____
Problem with stairs _____
Fine finger movement difficulties _____
Walking or balance problems _____

Patient Signature: _____ Date: _____

Memorial Orthopedic Surgery and Sports Medicine

CONTROLLED SUBSTANCE AGREEMENT
Updated 2016

The purpose of this Agreement is to enter a mutual contract regarding certain medicines (controlled substances) you will be taking or could be taking in the future. Prescription of. Controlled substances is strictly monitored by state and federal law so strict accountability is necessary.

- **I understand that this Agreement is based on the trust and confidence** necessary in a provider/patient relationship and that my provider will manage controlled substances based on this agreement. Pt. Initials _____
- **I understand that if I break this Agreement**, my provider will stop prescribing these controlled substances. Pt. initials _____
- **I agree to notify my provider of any and all controlled substances or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur within two (2) weeks, or sooner if I have an encounter with my provider, following receipt of prescription. If I fail to alert my provider I understand I may be discharged from the practice. Pt. initials _____
- **I understand that someday my provider may recommend weaning me partially or totally from controlled substances** if he/she determines that, in the long run, this is likely to be in my best interests. In such situations other medications or therapies will likely be suggested as part of my new treatment plan. I agree to respect my provider's opinion in such circumstances and comply with the new treatment plan or discuss pursing other treatment venues. Pt. Initials _____
- **I understand that if I am suspected of diverting or distributing my controlled substances, my provider will immediately cease** prescribing these medications. In this case, my provider will be required to comply with local state and/or federal reporting requirements and investigation. Pt. initials _____
- **I agree to consider to follow my provider's recommendation** to seek psychiatric treatment, psychotherapy, psychological treatment or referral to pain management specialist / addictionologist if my provider deems necessary. Pt initials _____
- **If the controlled substances are prescribed to treat pain symptoms, I agree to communicate fully and honestly with my provider** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. Pt initials _____
- **If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy**. I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations. Pt. Initials _____
- **I understand the combination of opiates or pain medications with anti-anxiety medications such as Valium or Xanax may increase the likelihood of side effects such as stopping breathing and/or abnormal heart rhythms which may result in injury or death.** Pt. initials _____
- **I understand that controlled substances which I may be prescribed have potential risks and side effects, including the risk of addiction**. An over-dosage with a controlled substance may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, reduced sexual function, seizures, coma, and/or aspiration. Pt. Initials _____
- **I will not use any recreational mind-altering or illicit (i.e. marijuana, cocaine, methamphetamine, etc.) substances.** Avoid use of alcohol as I understand alcohol may accentuate or exacerbate side effects associated with legal. Pt. Initials _____

- **I will not share, sell or trade my medication with anyone nor will take other individual's prescribed**. Pt. Initials _____

- **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider unless that provider is co-managing care with my current provider.** Pt. Initials _____

- I will inform my provider of ALL current medications including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit. Pt. Initials _____

- **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed.**
  Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to injury or death. Pt. Initials _____

- **I understand that suddenly stopping some medications** (including opioids and sedatives) can cause substantial discomfort including psychological distress, extreme achiness and fatigue, nausea, trembling, etc. Pt. Initials _____

- **I understand the abruptly stopping chronic higher dose use of benzodiazepines** can cause serious risk to my health and that weaning instructions must be followed explicitly. Pt. Initials _____

- I will avoid withdrawal symptoms by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that 'running out' of medication is not grounds for insisting on an 'emergency or urgent appointment'. Pt. initials _____

- I will safeguard my controlled substances from loss or theft. Lost or stolen medicines will not be replaced. Pt. Initials _____

- I agree that refills of my prescriptions for controlled substance will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. Pt. Initials _____

- I agree that prescriptions for controlled substances will not be refilled earlier than the agreed upon renewal date. Pt. Initials _____

- (Females Only) If t plan to become pregnant or believe that I have become pregnant while taking this/these medication, I will immediately call my obstetric provider and prescribing prescriber/provider to inform them. Pt. Initials _____

I agree to use _____ Pharmacy

Located at _____,

Telephone number _____, for filling prescriptions for **all of my controlled substance(s).**

- **If I chose to have my medications filled by a new pharmacy not listed above,** I will be required to sign a new Controlled Substance Contract at my next appointment with my updated pharmacy information. Pt. Initials _____

- **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law**. Forged prescriptions and/or forged provider's signatures are also against the law. If any of these instances occur, it will result in an immediate termination from this practice.
  Pt. Initials _____

- I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances. If requested, I authorize my provider to provide a copy of this Agreement to my pharmacy or to the requesting government agency. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
  Pt. Initials _____

- I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of controlled substance. Tests may include screens for illegal substances, and my cooperation is required. **Refusal of such testing may subject me to an abrupt/rapid wean schedule in order for the medication to be discontinued or prompt termination from this practice.** Pt. Initials _____

- **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time and possible termination of care.** Pt. Initials _____

- **I will bring all unused controlled substances to every office visit.** Pt. Initials _____

- **I understand that any serious misbehavior** such as yelling, threatening, cursing, etc. will likely be cause for dismissal from the practice. Pt. Initials _____

- **I agree to follow the guidelines that have been fully explained to me.** All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.
  Pt. Initials _____

This agreement is entered into on this _____day of _____,_____

Patient/Responsible party signature:

_____ Date: _____ Time: _____

Prescriber/Provider signature:

_____ Date: _____ Time: _____

Medication(s) prescribed: _____