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COMPREHENSIVE PAIN MANAGMENT CENTER
MOHAMMAD TARIQ, M.D.
MUHAMMAD ZULQARNAIN, M.D.

Completed - Print

PERSONAL INFORMATION

NAME: N/A DOB: N/A

HOME PHONE: N/A CELL: N/A WORK: N/A

ADDRESS: N/A

CITY: N/A STATE: N/A ZIP: N/A

SEX: M F MARITAL STATUS: S M W D AGE: N/A

SOCIAL SECURITY NUMBER: N/A EMPLOYER: N/A
EMPLOYER ADDRESS: N/A

REFERRING PHYSICIAN: N/A PHONE: N/A

PRIMARY CARE PHYSICIAN: N/A PHONE: N/A

EMERGENCY CONTACT

NAME: N/A RELATIONSHIP: N/A PHONE: N/A

INSURANCE INFORMATION

PRIMARY: N/A POLICY HOLDER: N/A

SSN: N/A DOB: N/A RELATIONSHIP: N/A

POLICY #: N/A GROUP #: N/A COPAY: N/A

SECONDARY: N/A POLICY HOLDER: N/A

SSN: N/A DOB: N/A RELATIONSHIP: N/A

POLICY #: N/A GROUP #: N/A COPAY: N/A

PLEASE SIGN AND RETURN TO RECEPTIONIST (PLEASE READ CAREFULLY BEFORE SIGNING)

I, THE UNDERSIGNED, ACKNOWLEDGE RECEIPT OF MEDICAL SERVICES AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM FOR HEALTH CARE PAYMENT ONLY. I AUTHORIZE PAYMENT TO THE PROVIDER. I ALSO UNDERSTAND THAT I SHOULD VERIFY COVERAGE WITH MY INSURANCE COMPANY AS WELL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE**. I WILL ALSO NOTIFY COMPREHENSIVE PAIN MGMT CENTER STAFF OF ANY CHANGES TO MY INSURANCE AND MY ADDRESS/PHONE.** We will bill your insurance company as a courtesy; however, any balance due is your responsibility. Payment will be requested from you if reimbursement from your insurance company is not received within 60 days.

SIGNATURE **DATE:** N/A

PLEASE MARK THE FOLLOWING THAT APPLIES TO YOU

Patient Name: _____**N/A**_____ DOB: _____**N/A**_____

	Varicose		
Diabetes	Veins/Phlebitis	Alcohol	Eye Pain
Seizures	Hemorrhoids	**0** oz per week	Failing Vision
Cancer	Constipation	Smoking	Double or Blurred Vision
Hernia	Diarrhea	**0** # years	Sleeping Difficulty
	Change in bowel		
Psoriasis	habits	**0** # per day	Anemia
Jaundice/Hepatitis	Bloodily or tarry stools	Coffee/Tea	Thyroid Disease
Tuberculosis	Abdominal pain	**0** # cups per day	Weight Loss-Recent
Eczema	Gall Bladder trouble	Muscle Weakness	Loss of Appetite-Recent
Herpes	Gout	Arthritis	Peptic Ulcer
Rheumatic Fever	Asthma/Wheezing	Osteoporosis	Difficulty Swallowing
Phobias	Shortness of Breath	Rheumatism	Frequent Sore Throat
Scarlet Fever	(on exertion)	Recurrent Back Pain	Prolonged Hoarseness
Hives	Stroke	Leg Pain when walking	Nausea/Vomiting
Polio	Bronchitis	Numbness	Allergies
Mumps	Chronic Cough	Tingling Sensations	Hay Fever
Chicken Pox	Pneumonia/Pleurisy	Foot Pain	Sinus Trouble-persistent
Measles	Dizzy Spells	Swollen Ankles	Recurrent Nose Bleeds
German measles	Fainting Spells	Tremor/Hands Shaking	Venereal Disease
Crohn's Colitis	Chest Pain	Headaches-Frequent	Menstrual Flow
Diverticulosis	Heart Murmur	Kidney Stones	( ) reg. ( ) irreg
Heartburn	Palpitations	Urethral Discharge	Pain/Cramps
Mental Illness	Irregular Pulse	Blood in Urine	Length of Cycle **N/A**
		Frequent Urine	
Memory Loss	Chronic Fatigue	Infections	Date of Last Period **N/A**
Moodiness-			
Excess	Cold Numb Feet	Decreased Hearing	Decrease in force/flow
Nervousness	High Blood Pressure	Frequent Ear Infections	Pain/Bleeding during sex
Depression	Bone FX/Joint Injury	Ringing in Ears	Pain/Bleeding after sex
Rashes	Bruise Easily	Hepatitis	

Are you ALLERGIC to any medications? ( ) Yes ( ) No

If yes please list medications you are **allergic** to

N/A

N/A

N/A

N/A

List any/all current medications and dosage you are presently taking and how you are taken them:

	Name Of Medication	Dosage (mgs)	Frequency	Method
1.	**N/A**	**N/A**	**N/A**	**N/A**
2.	**N/A**	**N/A**	**N/A**	**N/A**
3.	**N/A**	**N/A**	**N/A**	**N/A**
4.	**N/A**	**N/A**	**N/A**	**N/A**
5.	**N/A**	**N/A**	**N/A**	**N/A**

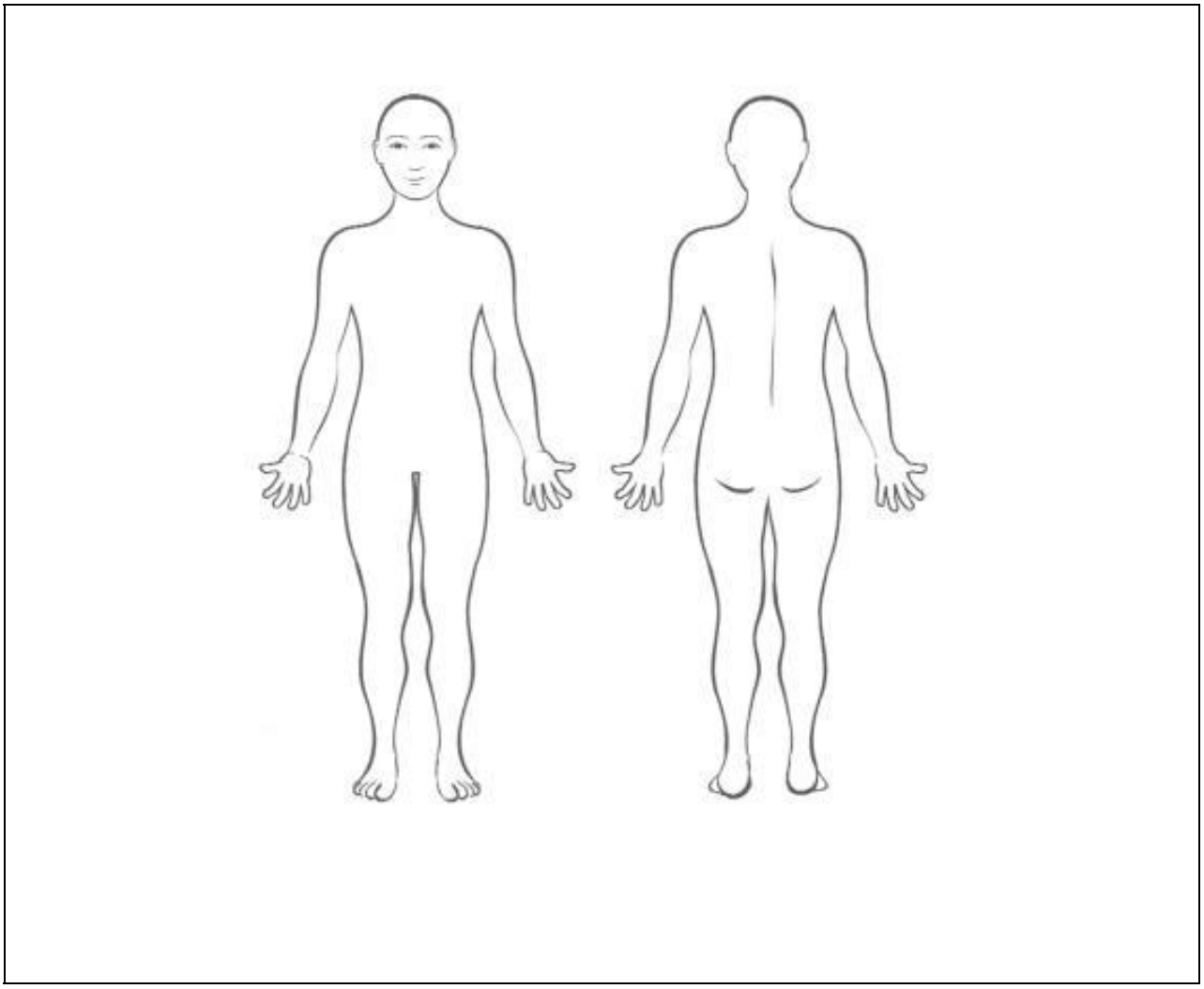
Please list the names, addresses, and phone numbers for all physicians you have seen for your pain.

	Doctor's Name	Doctor's Address	Doctor's Phone
1.	**N/A**	**N/A**	**N/A**
2.	**N/A**	**N/A**	**N/A**
3.	**N/A**	**N/A**	**N/A**

BODY MARKS

I _____**N/A**_____, request that payment of authorized insurance benefits, including Medicare, other government sponsored programs, private insurance and other health plans be made payable to Comprehensive Pain Management for the services rendered to me. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be financially responsible for all changes, whether or not paid by said insurance. I authorize any holder of medical or other information about me; to release any information needed to determine these benefits for related services. I understand that I am responsible for any unpaid balance that my insurance does not paid.

Write an X or X's on the figure below to indicate you main pain area. If your pain sensations spread, use arrows to show where it spreads.



SIGN: _____DOB:_____**N/A**_____

DATE:_____**N/A**_____

PATIENT AUTHORIZATION FORM

I, _____**N/A**_____, hereby authorize you to release specific information regarding

- o Treatment
- o Medications
- o Procedure results
- o Billing matters

To the following listed family members. I understand if they are not listed, this office is obligated by law to refuse to disclose any information.

Family Member Name & Relation:		Phone Number:
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**

I, _____**N/A**_____, hereby;

- o Authorize you to leave messages at Home/Work on Voice Mail.
- o Do Not Authorize you to leave messages at Home/Work on Voice Mail.

Regarding billing and/or any scheduled appointments.

_____ _____**N/A**_____

Patient/Guardian Signature Date

I, _____**N/A**_____, understand that if I wish to revoke any or all of this authorization that it will be my responsibility to provide it in writing to this office. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

_____**N/A**_____ _____**N/A**_____

Patient/Guardian Signature DOB Date

COMPREHENSIVE PAIN MANAGEMENT CENTER
MOHAMMAD TARIQ, M.D.
MUHAMMAD ZULQARNAIN, M.D.

Please initial each line below to indicate you have read and understand each tab.

Treatment Agreement

____ I promise full cooperation with my treating specialist whether by procedure or non-procedure means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications. The outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow Comprehensive Pain Management Center to release my Private Health Information to any and all of my insurance carriers, their third party payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practices to release my information or contact any and all of my treating physicians.

Patient Financial Policy

____ You are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all personal information (home address, phone numbers, etc…) and/or insurance changes and authorization referral requirements. In the event that our office is not informed, you will be responsible for any charges denied.

____ **Your portion of payment for office services is due at the time of service. We will accept VISA, MasterCard, Cash or Check.**

____ We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay at the time of service. If you are seeing our doctor on an "Out-of-Network" basis, you will be subject to those out of network rates.

____ Your insurance policy is a contract between you and you insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance company pay the doctor directly. **If your insurance company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact our billing department @ 972-316-3344 ext 105 with any questions.**

____ Not all services are a covered benefit in all insurance policies, some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "non-covered or pre-existing," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for any charges rendered. **For that reason we encourage you as the policy holder to get involved with you insurance prior to any procedure, for clarification of benefits prior to services rendered.**

____ Clinic days are 8:30am-3:30pm Tuesday in Lewisville and Wednesday in McKinney with limited appointments. Please honor our 48 hour reschedule notice, as there are other patients waiting to get an appointment. There is a $25 charge for office visit appointments and a $50 charge for procedures broken or cancelled without 48 hours advanced notice. **Repetitive broken or cancelled appointments and/or non-compliance may result in a transfer of your care to an alternative practice.**

____ We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Any payment exceptions will be agreed upon in writing with either our billing department or the office manager.

____ Past due accounts are subject to collection proceedings. All fees included, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

____ **There is a service fee of $25 for all returned checks**. Upon an NSF or Closed Account occurrences, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be required from the District Attorney's Office.

____ Accounts no longer maintaining a financial "Good Faith" status, will result in the termination of the Comprehensive Pain Management Center Doctor-Patient relationship.

Authorization of Payment

____ I hereby assign all Medical Benefits directly to Comprehensive Pain Management Center for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or the office manager.

N/A	N/A		N/A
Print Patient's Name	DOB	Signature of Patient/Guardian	Date
Print Office Witness Name		Signature of Office Witness	Date

MOHAMMAD TARIQ, M.D.
MUHAMMAD ZULQARNAIN, M.D.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

The Health Insurance Portability & Accountability Act of 1996 is a federal program that requires that all medical records and other individually identifiable health information, or protected health information ("PHI") used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to request, inspect, and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken. Your ability to restrict disclosures also relates to prohibitions and permissions set in place by you regarding our ability to disclose of your PHI to your family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree, we must abide by it unless you agree in writing to remove it.

OUR RESPONSIBILITIES:

Comprehensive Pain Management Center is required to maintain the privacy of your health information. We will provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of these reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice at our office. We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMAITON OR TO REPORT A PROBLEM:

If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (I) correct and complete; (ii) not created by us and/or not part of our records, or; (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial along with any statement in response that you provide, amended to your PHI. If we approve the request for amendment, we change the PHI and so inform you, and tell others what they need to know about the change in the PHI.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Comprehensive Pain Mgmt Center will record the actions taken and observations made with respect to your information.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well your diagnosis, procedure, and medications provided.

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

We may disclose to the FDA health information relative to adverse events with respect to supplement, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. We must obtain your authorization separate from any notice we may have provided to you. If you give us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

Mohammad Tariq, M.D.
Muhammad Zulqarnain, M.D.

By signing this form and returning it to Comprehensive Pain Management, I acknowledge that I have received a copy of this notice of the privacy practices.

N/A	N/A
Printed Name of Patient	**DOB**

	N/A
Authorized Signature of Patient	**Date**

COMPREHENSIVE PAIN MANAGEMENT CENTER

1850 Lakepointe Drive, Ste 100
Lewisville, Texas 75057

4510 Medical Center Dr Ste 110
McKinney, Texas 75069

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3RD ADDITION: Developed by the Texas Pain Society, April 2008 (www.texaspain.org)

NAME OF PATIENT: _____**N/A**_____ **DATE:**____**N/A**____

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 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 prescriptions(s) for dangerous and/or controlled drugs (medication) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioids/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 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 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 deemed necessary, and I hereby give permission to perform 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 the course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or 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 and 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 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 the appropriate treatment goal may also mean the eventual withdrawal from the use of 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 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 no warranty or guarantee has been made to me as to the results of any drug therapy or cure of my 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 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 managements agreement relates to my use of any and all medications(s) (i.e., opioids, also called "narcotic 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 will **NOT drink alcohol while** taking narcotics/opioids medication prescribed by any 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 medications; nor will I give or sell them** to anyone else.
- I understand that my medication(s) may or may not be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money, **if they are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date.** However early refills may be 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 has run out. **All REFILL REQUESTS MUST BE RECEIVED BY 2PM MONDAY THRU FRIDAY ON OUR FAX OR THE PRESECRIPTION WILL NOT BE FILLED IF DUE UNTIL THE NEXT BUSINESS DAY. I FURTHER UNDERSTAND THAT THE ANSWERING SERVICE WILL NOT CONTACT THE PHYSICIAN AFTER HOURS TO REFILL A PRESCRIPTION.**
- I will receive medication(s) **only from one physician** unless it is 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 another doctor(s) that has not been approved by my physician may lead to 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 a referral to an expert may be necessary; such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologists 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.

COMPREHENSIVE PAIN MANAGEMENT CENTER
Mohammad Tariq, M.D.
Muhammad Zulqarnain, M.D.
1850 Lakepointe Drive, Ste 100
Lewisville, Texas 75057
4510 Medical Center Dr Ste 110
McKinney, Texas 75069

- 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 or the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.
- 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 authorize the physicians of Comprehensive Pain Management to provide a copy of this agreement to my pharmacy. I authorize my physician to release my medical records to my pharmacist as needed. I agree to waive any applicable privilege or right privacy or confidentiality with respect to these authorizations.

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 explanation regarding the benefits and the risks of these medications and I agree to the use of these medications in the treatment of my chronic pain.**

N/A _____ **N/A** _____ _____

Patient Name (print) DOB Patient Signature

_____

Physician Signature (or appropriately authorized assistant)

N/A _____ **N/A** _____

Name and contact information for the Pharmacy

NOTICE

TO ALL NEW AND ESTABLISHED PATIENTS PLEASE BE AWARE THAT BOTH DR. TARIQ AND DR. ZULQARNAIN WORK TOGETHER AS A TEAM TO PROVIDE THE BEST QUALITY OF CARE AND SERVICE TO OUR PATIENTS.

BOTH PHYSICIANS ARE BOARD CERTIFIED IN ANESTHESIOLOGY AND PAIN MANAGEMENT AND WORK TOGETHER AS A TEAM.

WHILE YOU MAY HAVE SEEN ONE OF THESE DOCTORS ON AN INITIAL VISIT, AN INJECTION, FOLLOW-UP OR A MEDICATION CHECK YOU MAY BE SCHEDULED WITH THE OTHER DOCTOR ON ANY FUTURE OR SUBSEQUENT VISITS.

COMPREHENSIVE PAIN MANAGEMENT CENTER