COMPREHENSIVE
Pain Management Center

Patient Name: _____ **DOB:** _____ **Date:** _____

Complete with Address Changes Only: _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Circle words that Describe your pain:

Aching Throbbing Shooting Stabbing Gnawing Exhausting Tender Burning Sharp

Tiring Deep Penetrating Miserable Tingling / Numbness Radiating Unbearable Nagging

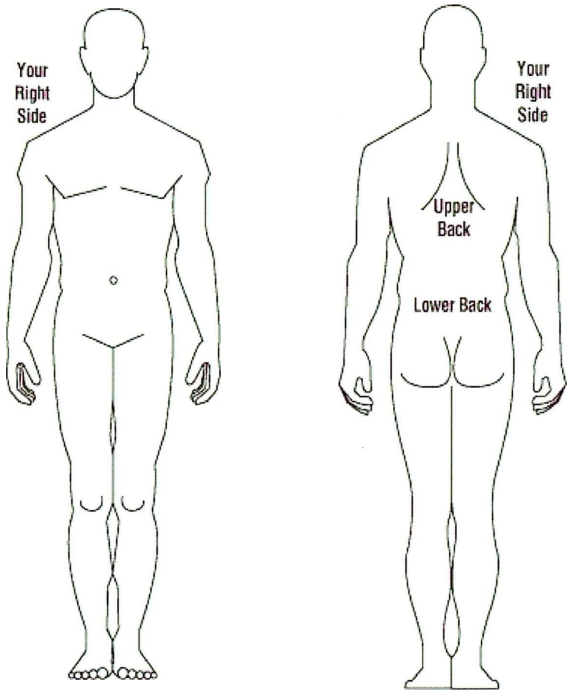
Where is your pain located: _____

What Time of Day is your pain Worse? (Circle Times) **Morning** **Afternoon** **Evening** **Night-Time**

What makes your pain BETTER? _____

What makes your pain WORSE? _____

Place an X on the figure below to indicate your MAIN pain area.
If your pain sensation spreads, use arrows to trace the pain to where it stops.



Rate your pain from 0-10 that describes your PAIN:

RIGHT NOW: _____

On AVERAGE: _____

At its LEAST LAST MONTH: _____

At its WORSE LAST MONTH: _____

PROCEDURE FOLLOW-UP

Rate your pain from 0-10

BEFORE: _____

AFTER: _____

What treatment or medication are you receiving for your pain?

_____

Rate your treatment or medication relief:

No relief 1 2 3 4 5 6 7 8 9 10 Complete Relief

BACK

COMPREHENSIVE
Pain Management Center

Opioid Risk Tool

Patient: _____ DOB: _____

Please mark with a Yes or No under the column that applies to your gender.

(Only Mark under the Column that applies)	**Female**	**Male**
Family History of substance abuse		
Alcohol		
Illegal Drugs		
RX Drugs		
Personal History of Substance Abuse		
Alcohol		
Illegal Drugs		
RX Drugs		
Are you between the ages of 16 - 45 yrs.?		
History of pre-adolescent sexual abuse		
Psychological Disease		
ADHD, OCD, Bipolar, Schizophrenia		
Depression		

(For office use only) Scoring Total: _____

COMPREHENSIVE
Pain Management Center

Patient Health Survey

Patient Name: _____ DOB _____

Medical History

Diabetes	Varicose Veins / Phlebitis	Osteoporosis	Thyroid Disease
Seizures	Hemorrhoids	Pneumonia	Recent Weight Loss
Cancer	Constipation	Recurrent Back Pain	Recent Loss Appetite
Hernia	Diarrhea	Leg Pain while walking	Peptic Ulcer
Psoriasis	Bloodily / Tarry Stools	Numbness / Tingling	Difficulty Swallowing
Jaundice / Hepatitis	Abdominal Pain	Foot Pain	Frequent Sore Throat
Tuberculosis	Gall Bladder Issues	Swollen Ankles	Hoarseness
Eczema	Gout	Tremor / Hands Shaking	Nausea / Vomiting
Herpes	Asthma / Wheezing	Frequent Headaches	Allergies
Rheumatic Fever	Shortness of Breath	Kidney Stones	Hay Fever
Thrombosis	Stroke	Urethral Discharge	Persistent Sinus Issues
Scarlet Fever	Bronchitis	Blood in Urine	Nose Bleeds
Hives / Rashes	Chronic Cough	Frequent Urine Infection	AIDS/HIV
Polio	Pneumonia / Pleurisy	Decreased Hearing	
Mumps	Dizzy / Fainting Spells	Frequent Ear Infection	Menstrual Flow:
Chicken Pox	Chest Pain	CAD / Heart Issues	____ Regular
Measles	Heart Murmur	Ringing in Ears	____ Irregular
Crohn's Colitis	Palpitations	Venereal Disease	Pain / Cramping
Diverticulitis	Irregular Pulse	Bruise Easily	Length of Cycle: _____
Heart Burn / Acid Reflux	Chronic Fatigue	Eye Pain	Date of Last Cycle: _____
Mental Illness	Cold Numb Feet	Failing Vision	Pain/ Bleeding during Intercourse
Memory Loss	High Blood Pressure	Double / Blurred Vision	
Excess Moodiness	Bone Fracture/ Joint Injury	Sleep Apnea	
Nervousness	Muscle Weakness	Insomnia	
Depression / Anxiety	Arthritis	Anemia	

Medications & dosage: Directions/How Taken: Drug/Food Allergies:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Social History:

_____ Smoker _____ Former Smoker _____ Non-Smoker
per day _____ #Yr _____ Interested in Quitting? Yes No
Alcohol: Yes No How often? _____ # Drinks _____
Activity Level: Low Moderate Active

Illegal drug Use? Yes No Type _____
Addicted to Prescription Medications? Yes No
If so, what type? _____
Caffeine: Yes No # cups per day? _____

Names and Phone Numbers of other physicians who have treated you for pain:

_____
_____

COMPREHENSIVE
Pain Management Center

751 Hebron Pkwy. Suite 200
Lewisville, TX 75057
P: 972-316-3344
F: 972-316-3322

RECURRING PAYMENT AUTHORIZATION FORM

PLEASE CAREFULLY READ AND ACKNOWLEDGE THE INFORMATION BELOW

I hereby authorize Comprehensive Pain Management to charge my credit card number listed below, on the date of service that I am scheduled for a virtual or in-office visit. I do understand that the amount due may change each visit if I have a co-insurance instead of a fixed copay or if I have to meet deductibles or out of pocket costs before my plan pays on my behalf. It is my responsibility to find out what my out of pocket costs would be by calling my plan directly ahead of my scheduled visits. When necessary, Comprehensive Pain Management will credit my account for any charges that were made in excess of what my health plan put towards my financial responsibility and that credit will be applied to future visits or outstanding balances (if any) automatically. **Please note that in case you miss your appointment and had not notified us at least 24 hours in advance of your scheduled appointment, a "no-show fee" of $50 will be charged to your credit card on the day of the missed appointment.**

This Recurring Payment Authorization is to remain in full force and effect until Comprehensive Pain Management has receives written notification from me of termination of this service in such time and in such manner as to afford Comprehensive Pain Management a reasonable opportunity to act upon it. Written notice may be provided either in person or mailed to the address above.

If you think your monthly statement is incorrect or if you need more information concerning a transaction on your statement, please contact our office at the numbers listed above. We will make any necessary adjustments to your account within 30 days. After 60 days following a claimed DOS, all charges will be assumed correct.

By signing below, I acknowledge that I have read and understand the information included on this form and agree to all the terms and conditions of this contract.

Signature _____ Date _____

Please complete the payment information below

CREDIT CARD Information (please check one) ☐ **VISA** ☐ **MASTERCARD** ☐ **AMEX** ☐ **DISCOVER**

Name of the card holder		
Credit card number	**Expiration month/year**	**CVV code**

COMPREHENSIVE
Pain Management Center

Mohammad Tariq, M.D

Personal Information

Name: _____ DOB _____
Address _____
City_____ State _____ Zip _____
Social Security #: _____ Sex: M F Marital Status: S M W D

Contact Information

Cell: _____ Home: _____ Work _____

E-mail Address: _____

Please mark below how you are willing to receive communication from the office staff:

_____Phone Calls _____ Emails _____Text Messages *By checking this box you agree to receive recurring messages from North Dallas Pain Management Center, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

_____Please place a check mark if we can leave a detailed voice mail.

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Insurance Information

PRIMARY INSURANCE COMPANY_____ Member ID: _____ Group #: _____

Subscriber:_____Subscriber's DOB:_____Relationship:_____

SECONDARY INSURANCE COMPANY_____ Member ID: _____ Group #: _____

Referring Physician: _____ Phone: _____Fax: _____

Primary Care Physician: _____ Phone: _____Fax: _____

PLEASE READ CAREFULLY BEFORE SIGNING: By signing this and returning it to the Receptionist; I, the undesigned, acknowledge receipt of medical service 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 Management Center staff of any changes to my insurance and my address/phone number. WE WILL BILL YOUR INSURNACE COMPANY AS A COURTESTY! HOWEVER, ANY BALANCE DUE IS YOUR RESPONSIBILITY.

PAYMENTS WILL BE REQUESTED FROM YOU, IF REIMBURSEMENT FROM YOUR INSURNÅCE COMPANY IS NOT REVCEIVED WITHIN 60 DAYS.

_____ _____

Patient Signature Date

BACK

COMPREHENSIVE
Pain Management Center

Mohammad Tariq, M.D

HIPAA
Patient Authorization Form

I, _____ hereby authorize you to release specific information regarding treatment 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 & Relationship:	Phone Number:	Disclosed Information:

I, _____ hereby authorize the staff to leave detailed messages on:

Cell Voicemail_____ Home Voicemail_____ Work Voicemail _____Text massages _____

I, _____ understand that if I wish to revoke any or all of this authorization, 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 patient and no longer be protected by HIPPA.

_____ _____

Patient Signature Date

COMPREHENSIVE
Pain Management Center

Mohammad Tariq, M.D

Patient Name: _____ DOB: _____ DATE: _____

Consent

Please initial each line below to indicate you have read each statement and you understand!

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 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, act...) and/or Insurance changes and authorizations referral requirements. In the event our office is not informed, you will be responsible for any charges.
Your portion of payment for the office services is due at the time of service. We accept VISA, MasterCard, Discover, American Express, Check and Cash.

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. You will be required to pay the co-pay at the time of service. If you are seeing our doctor[s] on an "OUT OF NETWORK' basis, you will be subjected to those out of network rates.

Your Insurance policy is a contract between you and your 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 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 @ 732-395-7061 with any questions or concerns.

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 your insurance prior to any procedures. for clarification of benefits prior to any services rendered.

Clinic days are Monday through Thursday 8:30am to 4:30 pm and Friday 8:30am to 12pm. These days include our Lewisville, McKinney and Frisco Offices. Please honor our 24 hours reschedule notice, as there are other patients waiting to get an appointment. There is a cancellation fee if appointments or procedures are not cancelled within a 24-hour notice. The fee[s] are as follows: $25 charge for office visit and $50 charge for procedures. Repetitive cancelled appointments and/or non-compliance may result in a transfer of 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. Any payment exception will be agreed upon in writing with our billing department or office manager.

BACK

____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 to the office.

____There is a service fee of $25 for all returned checks. Upon NSF or Closed Account occurrences, all future remittances will need to be in other forms of payments. 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.

I,_____, request that payment of authorized Insurance benefits, including Medicare, other government sponsored programs, private insurance and other health plans be made to Comprehensive Pain Management for services rendered to me. This assignment shall remain in effect until revoked by me in writing. A photocopy of the assignment is to be financially responsible for all changes, whether or benefits for related services. I understand that I am responsible for any unpaid balance that my insurance does not pay.

Authorization of Payment

I hereby assign all Medical Benefits directly to Comprehensive Pain Management Center for the payment of nay 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 you care and treatment. If you have any questions. please discuss them with our front office staff or office manager.

Patient Signature:_____ Date:_____

Office Witness Signature:_____ Date: _____

COMPREHENSIVE
Pain Management Center

Mohammad Tariq, 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 Read Carefully!

UNDERSTANDING YOUR HEALTH RECORDIINFORMATION

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 to disclose by us in any form, whether electronically, on paper or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA 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 compiled it, the information belongs to you. You have the right to request, inspect, and obtain a copy of your health records, obtain an accounting disclosure of your health information, request communication 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 you PHI to your family members, close personal friends, or any other individual 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 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 responsible 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 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 the notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe that there is a mistake or missing information in our records 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 part of our records; or (iii) not permitted to be disclosed. Any denial will state the reason 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 that they need to know about the changes in the PHI.

BACK

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 members of your healthcare team will be recorded in your record and used to determine the Couse of treatment that should work best for you. Comprehensive Pain Management 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 as your diagnosis, procedures performed 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 information to enable products 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 you specific, written authorizations. We must obtain your authorizations separate from any notice we may have provided you. If you give us authorization to use or disclose health information about you, you must revoke the 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.

By Signing this form and Returning it to Comprehensive Pain Management Center I acknowledge that I have received a copy of the notice of the privacy practices.

_____ _____

Patient Signature DOB Date

COMPREHENSIVE
Pain Management Center

Mohammad Tariq, M.D

INFORMED CONSENT FOR Chronic Narcotic Analgesic Therapy
AND

Pain Management Agreement

as Required by the TEXAS MEDICAL BOARD

Reference: Texas Administrative Code, TITLE 22, Part 9, Chapter 170

Patient Name: _____ DOB _____ 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 medication(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather an effort to make you better informed so that you may give or withhold your consent/permission to use the medication(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 medication(s) 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 list is not comprehensive and that it only describes the most common side effects or reactions, and that death is also a possibility as a result of taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATELY FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATION(S) FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE PHARMACUTICAL 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.

BACK

I UNDERSTANT THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCURE IN THE USE OF THE MEDICATION(S) 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 judgement, 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.

You should NOT drive or operate machinery if the medication makes you drowsy! It usually takes 5 to 7 days for a person to get an idea of how he/she is affected. Frequently these effects diminish in a few days. Any time your dose is increased you may experience sedation and if sedation occurs you should not operate vehicles or machinery until sedation resolves.

Cognitive Impairment or mental clouding may occur during treatment and may or may not decrease over time. If the medication is used with other sedatives or alcohol the resulting heightened impairment is potentially dangerous. It **is strongly advised NOT to use alcohol** while taking narcotic medication.

Constipation is a common side effect. If this is a problem for you, try a stool softener (Docusate or Colace) or a mild laxative with increased fiber and fruits in your diet. Some people experience nausea with narcotic medications. If you take these medications after you eat, nausea may be decreased. Other side effects that infrequently occur are disorientation and sleep disturbances.

The use of other medications can increase side effects. It is important that your physician knows of any and all medications you are taking. All medications that make you sleepy (ex: Antihistamines in cold preparations and alcohol) will make you sleepier while taking narcotic medications. It is advised that you talk with your physician or pharmacist before buying over-the-counter products.

Risk of psychological dependence may occur in probably less than 1% of patients being treated with narcotic analgesics. This means there is a continued desire for the mood altering and other psychological effects of the medication and concerns for its continued availability. Communication with your physician is necessary for you to understand the role of the medications in your pain management program and to avoid development of this type of dependence.

Risk of physical dependence on these types of medication is very high. It refers to the fact that at higher doses of these types of medications, your body will get used to them. If you stop taking the medication abruptly, your body may react adversely with withdrawal symptoms, which may include excessive tearing, runny nose, dilated pupils, "goose pimples" flesh, sweating, yawning, diarrhea, muscle aches, headaches and insomnia. To prevent these uncomfortable symptoms, you should take your medication regularly and communicate to our physician any side effects. When discontinuing use of these medications, taper it down slowly over a period of a few days to a few weeks under supervision of your physician.

I HAVE BEEN INFORMED AND UNDERSTAND that I will undergo medical tests and examinations before and during my treatment. Those test(s) include random unannounced urine drug tests, pill counts, and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform these tests, or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in myself being discharged from this clinic's care.

For female patient's 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 do 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 the use of these medication(s) and hold my physician harmless for injuries to the embryo/fetus/baby.

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 the 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 medication(s) to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefits. I have been given the opportunity to ask questions about my condition and treatment, risks of nontreatment 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

This pain management agreement relates to my use of ANY and ALL medication(s) (i.e., opioid, also called “narcotics, painkillers, and other prescription medication(s), 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.

By signing this contract, I CERTIFY THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

- 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 medication(s).
- I will NOT allow or assist in the misuse or diversion of my medication(s); nor will I give or sell them to anyone else.
- All medication(s) must be obtained at ONE pharmacy, where possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED!
- Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

BACK

- 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), they 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, blood and/or saliva 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 substances(s), such as Speed, Heroin, 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 psychologist evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment. I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.
- I 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 judgement.
- 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.)
- 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.
- I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

Patient Signature Date

Pharmacy Name Address Pharmacy Phone Number

Physician's name and signature