Anesthesia Pain Care Consultants, Inc.

Patient Free Form Notes

PATIENTS NAME: SS#:

PATIENTS ACCT #:

Anesthesia Pain Care Consultants, Inc.

PATIENT INFORMATION: TODAYS DATE: _____ **EMAIL Address:**_____

Name: Sex: ____ Date of Birth: ____/____/____ Age: ____

Address: _____ Tele: (_____)_____

City: _____ State: _____ Zip: _____ SS#:

Employer: _____ Tele: (_____)_____

Address: _____ City: _____ State: ____ Zip: _____

Driver Lic. # /State: _____ Marital Status: S D W M Spouse:_____

NEAREST RELATIVE (EMERGENCY CONTACT):

Name: _____ Relationship: _____ Tele: (____)_____

Referring Physician's Name: _____ MD/DO Tele:(_____)_____

Family Physicians Name: _____ Tele: (_____)_____

INSURANCE INFORMATION:

Medicare, Individual Health, Group Health, Auto, HMO, PPO, Self-Pay, LOP (circle one)

Medicare patients just circle Medicare and give us your *secondary* insurance information.

All patients provide us with your Insurance Cards, both Primary and Secondary. We will Photo copy them for our files. All HMO patients and patients with a per visit co-pay amount, co-pay amount will be collected at time of visit. Please be prepared to pay per visit co-pay.

Primary Ins Co.: _____ Tele: ( ) _____

Member ID #: _____Group #_____ Co-pay amount: $_____

Address: _____ City: _____ State: ____ Zip:_____

Secondary Ins Co.: _____ Tele: ( ) _____

Address: _____ City: _____ State: ____ Zip:_____

AUTO ACCIDENT/PERSONAL INJURY (if applicable)

Date of Injury: ____/____/____ State in which accident occurred: _____

Insurance Co.: _____ Tele: ( ) _____

Address: _____ City: _____ State: ____ Zip:_____

Insured's Name: _____ Claim #: _____

Your Attorneys Name: _____ Tele: ( ) _____

Anesthesia Pain Care Consultants, Inc.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

All Other Insurance Companies and/or Third Party Payers

I HEREBY ASSIGN all medical and surgical benefits, to include major medical benefits to which I am entitled. I authorize Anesthesia Pain Care Consultants, Inc. and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediates for all services rendered by the physicians and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Anesthesia Pain Care Consultants, Inc. and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediates regarding services rendered.

Medicare

I certify that the information given by me in applying for payments under title XVII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration, Medicare, or its intermediaries or carriers any and all information needed for this or a related Medicare claim. I authorize and request that payment be made directly to Anesthesia Pain Care Consultants, Inc.

Medicaid

The physicians of Anesthesia Pain Care Consultants are NOT providers for the Medicaid Program. Any allowable services not paid by your primary insurance such as Medicare shall be billed directly to you. You are responsible for the deductible and/or copay portions of your bill.

Guarantee of Payment

I UNDERSTAND and agree that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Anesthesia Pain Care Associates, Inc. to me or the patient as indicated. By signing this document, I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed due to personal injury/accidents/illnesses. **I acknowledge that I am responsible to pay for services that my insurance deems to be non-covered and/or experimental services.**

Attorney's or Collection Fees

In the event a legal suit or outside collections are necessary to enforce payment of the account, the patient agrees to pay for all collection fees and/or attorney's fees and court costs as may be deemed reasonable

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one at a later date.
A photocopy of this assignment is to be considered as valid as the original.

PATIENT NAME:

PATIENT SIGNATURE: _____

DATE: _____

[If patient is 12 years or older, his/her signature is required in addition to the responsible party.]

RESPONSIBLE PARTY: (If other than patient) :_____

DATE: _____
(This does not apply to insurance companies or employers)

RESPONSIBLE PARTY INFORMATION:
Name: _____

Employer Name and Address: _____
_____

Tele: (_____)_____ SS# _____

Anesthesia Pain Care

HIPAA Notice of Privacy Practices

Anesthesia Pain Care Consultants
7171 N University Drive STE 300
Tamarac, FL 33321
954-720-3188

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature_____ Date: _____

Anesthesia Pain Care

NOTICE TO ALL PATIENTS

When a physician at Anesthesia Pain Care Consultants refers you to a specialist and you do NOT make an appointment to see that specialist, you, the patient will be held responsible for any adverse results involving your medical care.

When a physician at Anesthesia Pain Care Consultants refers you for any medical testing, such as lab work or x-rays and you do NOT have the testing done, you, the patient will be held responsible for any adverse results involving your medical care.

If you do proceed with our referrals PLEASE ask that care giver to FAX REPORTS and/or RESULTS to 954-722-6996. Also bring the reports and/or results to your next scheduled follow up visit.

If you have any questions regarding this notice, please speak to one of our staff members.

_____ _____

Patient name (printed) Patient signature

_____

Date

Office Address: 7171 N University Drive 3rd Floor – Tamarac, FL 33321 - Phone: 954-720-3188

The Surgery Center of Ft. Lauderdale
4485 North State Road 7
Lauderdale Lakes, Florida 33319
Telephone (954)735-0096 Fax (954) 739-5995

PATIENT RIGHTS

- Receive access to equal medical treatment and accommodations regardless of race, creed, sex, national origin, religion or sources of payment for care.
- Be fully informed and have complete information, to the extent known by the physician, regarding diagnosis, treatment, procedure and prognosis, as well as the risks and side effects associated with treatment and procedure prior to the procedure.
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Personal privacy.
- Receive care in a safe setting.
- Be free from all forms of abuse or harassment.
- Receive the care necessary to regain or maintain his or her maximum state of health and if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience, as well as perform the services for which they are responsible with the highest quality of services.
- Be fully informed of the scope of services available at the facility, provisions for after-hours care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.
- Make informed decisions regarding his or her care.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care of treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Access to and/or copies of his/her medical records.
- Be informed as to the facility's policy regarding advance directives/living wills.
- Be fully informed before any transfer to another facility or organization and ensure the receiving facility has accepted the patient transfer.
- Express those spiritual beliefs and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Expect the facility to agree to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Have an assessment and regular assessment of pain.
- Education of patients and families, when appropriate, regarding their roles in managing pain.
- To change providers if other qualified providers are available.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state laws may exercise the patient's rights to the extent allowed by state law.

PATIENT RESPONSIBILITIES

- Be considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.

- Keeping appointments and, when unable to do so for any reason, notifying the facility and physician.

The Surgery Center of Ft. Lauderdale
4485 North State Road 7
Lauderdale Lakes, Florida 33319
Telephone (954)735-0096 Fax (954) 739-5995

- Providing care givers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting to care at the facility.
- Promptly fulfilling his or her financial obligations to the facility.
- Identifying any patient safety concerns.

ADVANCE DIRECTIVE NOTIFICATION

In the State of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to make decisions or unable to communicate decisions. The Surgery Center of Ft. Lauderdale respects and upholds those rights.

However, unlike in an acute care hospital setting, The Surgery Center of Ft. Lauderdale does not routinely perform "high risk" procedures. While no surgery is without risk, most procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during the your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official State forms are available at our facility.

If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

To report a complaint or grievance you can contact the facility Administrator by phone at (954) 735 – 0096 ext 226 or by mail at:

The Surgery Center of Ft. Lauderdale
4485 North State Road 7
Lauderdale Lakes, FL 33319

Complaints may be filed through the State of Florida Office of Consumer Services Unit at: 1-888-419-3456 or write to the addresses below:
Complaints against an ambulatory surgical center:

Agency for Health Care Administration
Consumer Assistance Unit
2727 Mahan Drive / BLDG 1
Tallahassee, Florida 32308

If you have a complaint against a health care professional and want to receive a complaint form:

Department Of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsman. Visit the Ombudsman's webpage on the web at: www.cms.hhs.gov/center/ombudsman.asp

DISCLOSURE OF OWNERSHIP

The Surgery Center of Ft. Lauderdale is proud to have a number of quality physicians invested in our facility. Their investment enables them to have a voice in the administration of policies of our facility. This involvement helps to ensure the highest quality of surgical care for our patients. Your physician **may** have a financial interest in this facility.

By signing this document, I acknowledge that I have read and understand its contents:

_____

Anesthesia Pain Care Consultants, Inc.
7171 N. University Drive #300 Tamarac, FL 33321 (954) 720-3188 Fax (954) 722-6996
Certified by American Board of Anesthesiology in Pain Management and Anesthesiology
Certified by American Board of Pain Medicine
Ira Fox, MD DABPM FIPP ABIPP - Cuneyt Ozaktay, MD
Kianfa Martinez, MD - Jay Lasner, MD DABPM FIPP ABIPP – Winston Parris, MD DABPM

Authorization for Release of Medical Records

I the undersigned authorize you to furnish a copy of or to allow my medical records to be inspected/reviewed. I authorize the release my medical records, exams, office notes to Anesthesia Pain Care Consultants, Inc.

Patient Name:

Patient Signature:_____

Patient Social Security Number: _____

I hereby authorize my treating physicians and other care givers to discuss my case with and release medical records to:

Name: Relationship:

_____

Office Use Only

Please send the last office notes and any CT - MRI - X-ray or EMG Reports via fax or mail.

Please send the following other information: _____

Anesthesia Pain Care Consultants

***PLEASE COMPLETE ALL Sections**

Patient Initial Assessment

Phone: **954-720-3188** Fax: **954-722-6996**

Patient Name: _____ Appointment with Dr: _____

Date of Birth: _____ Sex: Male / Female

Height: _____ Weight: _____

Status: New Patient / Established Patient

Referred by: _____

History of Present Illness (circle all that apply)

Chief Complaint: Back pain *upper mid lower*
Leg pain Hip pain Neck pain Other: _____

Onset: _____ mins / hrs / days / months / years ago
Acute Chronic Sudden Gradual

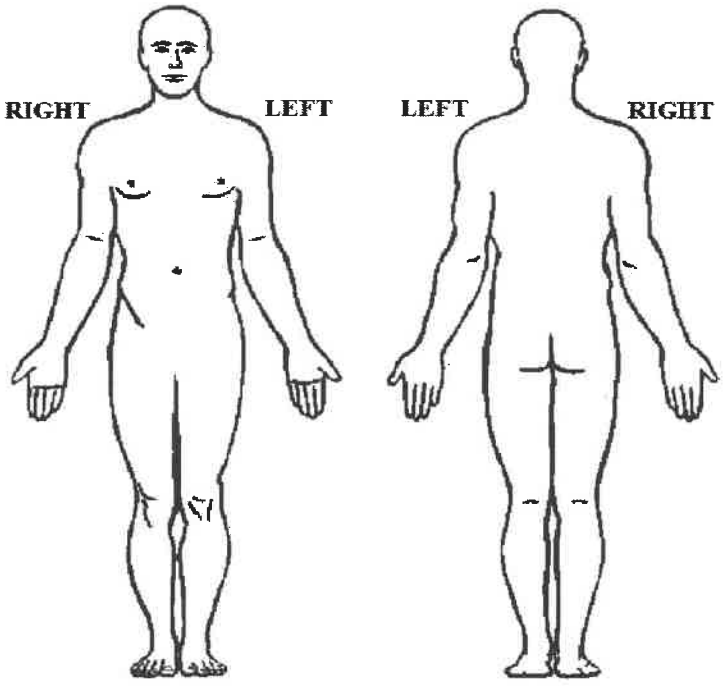
Severity: mild moderate severe (1/10): _____

Relieved by: none Bedrest Change in position Exercise Ice Medication Heat Physical Therapy Sitting Standing Bending forward Other: _____

Worsened by: none Sneezing Coughing Bending Twisting Straining at Stool Sitting Prolonged Sitting Standing Prolonged Standing Walking Lifting Other: _____

Interferes with: none Driving Walking Bathing Work Intercourse Pleasure Sleep Leisure Activity Other: _____

Place **X's** on areas where you are experiencing pain on diagram



Is the pain radiating? Draw a ⟶ to indicate

Any recent injury/trauma: Yes No _____

Quality of pain: Dull Dull Aching Sharp Stabbing Cramping Piercing Shooting Burning Electrical Numbness Tingling Catching

Associated Symptoms:
Fever/Chills Tingling Back Stiffness Neck Stiffness Neck Swelling Numbness Neck Spasm Crepitus Painful/Burning Urination Arm Weakness Hip pain Leg weakness Stool incontinence Urine Incontinence

Past Procedures/Therapy
(circle all that apply and enter year)

Cortisone Injections (year): _____
Success Partial Success Unsuccessful

Trigger point Injections (year): _____
Success Partial Success Unsuccessful

Peripheral Nerve Block (year): _____
Success Partial Success Unsuccessful

Epidural Steroid Injections (year): _____
Success Partial Success Unsuccessful

Facet Injections (year): _____
Success Partial Success Unsuccessful

Nerve Root Injections (year): _____
Success Partial Success Unsuccessful

Facet Nerve Neurolysis (year): _____
Success Partial Success Unsuccessful

Kyphoplasty (year): _____
Success Partial Success Unsuccessful

Chiropractor (years): _____
Success Partial Success Unsuccessful

Physical Therapy (years): _____
Success Partial Success Unsuccessful

Past Medical History (circle all that apply)

Cardiac Disease
Atrial fibrillation *Coronary Artery Disease*
Congestive Heart Failure *Heart Attack*
High Blood Pressure High Cholesterol
Diabetes *Type 1* *Type 2*
Back Pain Neck Pain Degenerative Disk Disease
Headaches Seizures GERD/Reflux Hiatal Hernia
Anxiety Kidney disease Rheumatoid Arthritis
Other:_____

Past Surgical History
(circle all that apply and enter year)

Laminectomy (year):_____
Cervical *Thoracic* *Lumbar*
Fusions (year):_____
Cervical *Thoracic* *Lumbar*
Joint Surgery: *Hip Replacement R or L (year):*_____
*Shoulder Replacement R or L (year):*_____
*Knee Replacement R or L (year):*_____
Pump Implant/Trial (year):_____
Abdominal Surgeries (year):_____
Spinal Cord Stimulator Trial/Implant (year):_____
Lumbar Back Surgery (year): _____
Thoracic Back Surgery (year): _____
Other:_____

Social History (circle all that apply)

Smoker non-smoker *Current* *Light* *Heavy* *Past*
_____ pack/day _____ Age began smoking
Alcohol *none* *Socially* *Rarely* *Regularly*
Drugs *marijuana* *Amphetamines* *Cocaine*
Heroin *Narcotics* Other:_____
Marital Status: *Single* *Married* *Divorced*
Separated *Widowed*
Present Living Situation: Alone with spouse
with significant other with children with parents
with friend Other:_____

Family Medical History (such as cardiac, diabetes)

Father:_____
Mother_____
Grandfather:_____
Grandmother:_____
Brother:_____
Sister:_____

Allergies

_____
_____
_____

Review of Systems (circle all that apply)

Fatigue	Active Angina
Fever	Palpitations
Weight Gain	Cough
Weight Loss	Coughing up Blood
Blurred Vision	Shortness of breath
Double Vision	Constipation
Eye Pain	Diarrhea
Ear Pain	Nausea
Throat Pain	Vomiting
Nasal discomfort	Neck Pain
Back Pain	Joint redness
Joint Pain	Joint Swelling
Leg Pain	Muscle Pain
Rashes	Wounds
Dizziness	Loss of balance
Bladder incontinence	Bowel incontinence
Anxiety	Depression
Insomnia	Excessive thirst
Excessive urination	Heat intolerance
Bleeding tendencies	Bruising tendencies
Hives	Nasal discharge
Watery eyes	

Previous Diagnostic Studies

EMG/Nerve conduction Study (year): _____

MRI (year): _____

CT scan (year): _____

X-ray (year): _____

Myelogram (year): _____

Bone Scan (year): _____

Diskogram (year): _____

Pharmacy Name and Phone: _____

Current Medication

Name of Drug	Dosage	How often

Circle any medications you have tried and indicate if it provided success, partial success, or no success to your pain by **placing a check** in the appropriate column.

Oral Opioids	**Success**	**Partial Success**	**No Success**
Morphine			
Dilaudid			
Methadone			
OxyContin			
OxyCodone			
Duragesic patch			
Percocet/Percodan			
Darvocet			
Vicoden/Hydrocodone			
Lortab/Norco			
Tramadol /Ultram			
Non-Steroidal Anti-inflammatory	**Success**	**Partial Success**	**No Success**
Aspirin			
Vioxx/Celebrex			
Mobic			
Ibuprofen (Advil/Motrin)			
Aleeve (Naprosyn)			
Anticonvulsants	**Success**	**Partial Success**	**No Success**
Neurontin			
Lyrica			
Muscle Relaxants	**Success**	**Partial Success**	**No Success**
Neurontin			
Lyrica			
Flexeril/Robaxin			
Soma			
Baclofen			
Skelaxin			
ZanaFlex			
Anti-Depressants	**Success**	**Partial Success**	**No Success**
Cymbalta			
Elavil			
Celexa			
Topical Compounding Medications	**Success**	**Partial Success**	**No Success**
Name type:			

Anesthesia Pain Care Consultants, Inc.
Ira Fox, MD DABPM FIPP ABIPP – Javier Vilasuso, MD –
Joseph Alshon, DO FAAPM&R, FAOCRM, DABPM – Cuneyt Ozaktay, MD
Jesse Hatgis, DO, DAOBPMR – Robert Levy, MD

Name: _____ Date: _____

CONSENT FORM FOR CHRONIC NARCOTIC PAIN MEDICATION

I am signing this agreement for regularly scheduled narcotic medication for pain control. I understand that my diagnosis is chronic intractable pain.

I am asking for narcotic pain medication because other treatments and medications I have received have not controlled my pain. It is unlikely that any medication will completely take away my pain, but for humane reasons narcotic pain medication will be given to me as long as my pain continues, provided that I follow the terms of this agreement.

I understand that the possible complications of chronic narcotic therapy include chemical dependence (addiction), constipation which could be severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, depressed respirations, and reduced sexual function. If I take more medication than what is prescribed a dangerous situation could result, such as coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly that I could have narcotic withdrawal symptoms, which can be uncomfortable or dangerous.

I understand that the possible complications of chronic narcotic therapy include chemical dependence (addiction), constipation which could be severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, depressed respirations, blurry vision, facial flushing, excessive sweating, abnormal and unexplained mood changes, and reduced sexual function. If I take more medication than what is prescribed a dangerous situation could result, such as coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, that I could have narcotic withdrawal symptoms, which can be uncomfortable or dangerous.

The alternative to this kind of medication is to continue using non-habit-forming medications or other types of pain treatment not involving medications, although probably no form of treatment will ever completely take away pain, whether or not I am taking medication. By signing this consent, I am agreeing to the following terms:

_____ Only the Physicians of Anesthesia Pain Care Consultants will prescribe me narcotic pain medication. I am not permitted to get such medication from any other doctor or clinic.

_____ A daily dosage will be chosen. After getting this dose for at least two weeks, one more adjustment in the dose will be allowed. After that, no more increases in dosage will be considered or permitted even though the medication may have less and less effect on the pain on a long-term basis and I understand that narcotics have less and less effect on pain when used for a long time.

_____ A urine drug screen will be ordered randomly at the doctor's discretion. I understand the urine drug screen must show prescribed medications and now show any illegal substances or unprescribed medications.

_____ I may be asked at the doctor's discretion to seek outside evaluation and possible psychiatric treatment for chronic opioid use.

_____ Our office may call local pharmacies for confirmation of prescriptions and to check to see that you are not receiving any other prescriptions from another doctor.

_____ The use of this medication will be strictly monitored and will come from one pharmacy. If I run out of medication early because I have been taking more than the correct amount, I will just have to wait until the next month's prescription. Extra medication will not be given if I run out early. Absolutely no calls for unplanned or emergency medication refills will be taken. If I develop a new injury or pain problem and am given narcotic pain medicine for this, the prescribing doctor must confirm with us.

_____ If I develop a new injury or pain problem which require an Emergency Room visit and/or new or additional narcotic pain medicine, I must provide appropriate documentation.

_____ An altered or forged prescriptions, and prescriptions I might get from doctors outside of the Physicians of Anesthesia Pain Care Consultants, or any attempt to sell or give my medication to somebody else will cause the agreement to be cancelled. If this happens, the Physicians of Anesthesia Pain Care Consultants will slowly reduce and stop my medication and will not give me any more narcotic pain medication. If I am getting absolutely no help from this medication, or if there are problems, the Pain Management Program doctors may need to slowly reduce and stop the medication. It may be necessary for me to enter a chemical dependence (addiction) program in order to take me completely off the medication.

Signed _____(patient) _____(date)

_____(Physician) _____(date)

_____(Witness) _____(date)