YOUR FAMILY MEDICAL
KEEPING YOUR FAMILY WELL

NEW PATIENT INFORMATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Even though we at Your Family Medical (YFM) are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, Opana, and methadone.

- Please bring your driver's license and insurance cards along with your completed new patient paperwork to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation.** ***If we do not have your films at the time of your appointment, you may be rescheduled.***
- NO CHILDREN are allowed in the clinic. Many of our patients are in wheelchairs and walkers and we see too many people to have children in the clinic. You will not be seen if you bring your children.
- If English is your second language, in order to provide you with the best health care service, please make arrangements for someone to accompany you to your visit who can translate. We want you to fully understand your diagnosis and prognosis and to answer any questions you may have.

Your Appointment is: _____

****If you have not filled out or completed the New Patient Packet, please arrive 30 minutes prior to your appointment.**

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions or concerns.

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NAME:_____ Date of Birth:_____ DATE:_____

Is this your legal name? ☐Yes ☐No

If no, LEGAL NAME: _____ FORMER NAME(S)? _____

_____ _____

NEW PATIENT INTAKE

Patient's Age _____ Gender: M ☐ F ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SSN: _____ DRIVER'S LICENSE #: _____

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino PREFERRED LANGUAGE: _____

RACE: ☐Native American ☐Asian ☐Black/African-American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other

RELIGION: _____ EDUCATION: _____

E-MAIL: _____☐@yahoo.com ☐@gmail.com ☐@hotmail.com

PREFERRED METHOD OF COMMUNICATION: ☐Home phone ☐Cell phone ☐Work Phone ☐E-mail

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

OTHER PHYSICIANS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY PHONE: _____ PHONE TYPE: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ DATE OF BIRTH:_____

ADDRESS:_____

RELATIONSHIP: _____ PHONE: _____ SSN: _____

EMPLOYER: _____ EMPLOYER PHONE:_____

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NAME:_____ Date of Birth:_____ DATE:_____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ **(Provide card to front desk)**

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED'S SSN: _____

RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Your Family Medical or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

PAST MEDICAL HISTORY

Please indicate if you have suffered from any of the following medical conditions. ***Also note the year these occurred.***

_____AIDS or HIV
_____Arthritis
_____Asthma
_____Cancer
_____Chronic skin disease
_____Depression
_____Diabetes
_____Emphysema
_____Fibromyalgia
_____Gallbladder
_____Gonorrhea
_____Gout
_____Headaches/migraine
_____Heart disease/attack
_____Heart failure
_____Heart murmur
_____Hepatitis
_____Herpes infection
_____High blood pressure
_____Hormone problems
_____Insomnia
_____Irregular heart beat
_____Jaundice
_____Kidney disease
_____Kidney Stones
_____Liver disease
_____Lupus
_____Menopause
_____Multiple sclerosis
_____Nervous breakdown
_____Other blood abnormality
_____Other venereal disease
_____Panic attacks
_____Peptic ulcer disease
_____Peripheral vascular disease
_____Pneumonia
_____Prostate enlargement
_____Rheumatic heart
_____Schizophrenia/bipolar
_____Seizures/convulsions
_____Shingles
_____Stroke
_____Syphilis
_____Thyroid
_____Tuberculosis
_____Urinary infection

Other: _____
_____
_____
_____

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NAME:_____ Date of Birth:_____ DATE:_____

PAST SURGICAL HISTORY

_____Date/Year_____ _____Date/Year_____

_____Date/Year_____ _____Date/Year_____

_____Date/Year_____ _____Date/Year_____

FAMILY HISTORY

List any disease, illness, or ailments in your IMMEDIATE FAMILY. (i.e. mother-breast cancer, father - diabetic, grandfather - heart disease)

_____

_____

SOCIAL HISTORY

Occupation: _____

Do you smoke? ☐Yes ☐No How many packs/day?_____ Years?_____

Drink alcohol? ☐Yes ☐No How much?_____

Use any other drugs (marijuana, cocaine, etc.)? ☐Yes ☐No If yes, what?_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Live Alone? ☐Yes ☐No If no, who do you live with? _____

REPRODUCTIVE HISTORY

Women:

Age when menstrual cycle began: _____ Date of last period: _____

Difficulty with periods? ☐Yes ☐No

Total pregnancies_____ How many live births? _____

Miscarriages or abortions? ☐Yes ☐No How many? _____

Any medical problems associated with pregnancy or any other gynecological illnesses? ☐Yes ☐No

History of breast disease? ☐Yes ☐No Do you perform regular breast exams? ☐Yes ☐No

Date of last PAP smear_____ Date of last mammogram_____

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NAME:_____ Date of Birth:_____ DATE:_____

REPRODUCTIVE HISTORY

Men:

Do you perform regular testicular self-exams? ☐Yes ☐No

Any problems with testicular, prostate, or infertility? ☐Yes ☐No If yes, please explain:_____

ALLERGIES _____

PHARMACY Name:_____Location:_____

CURRENT MEDICATIONS **include dosage and frequency for each

Medication	Dosage	Frequency

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that needs further explanation please indicate such and explain in additional notes section.

General	YES	NO
Loss of appetite	☐	☐
Fever or chills	☐	☐
Eyes	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐
Head/ear/nose/throat	☐	☐
Hoarseness	☐	☐
Trouble swallowing	☐	☐
Cardiovascular	☐	☐
Chest pain	☐	☐
Leg swelling	☐	☐
Varicose veins	☐	☐

Respiratory	YES	NO
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal	YES	NO
Nausea and vomiting	☐	☐
Ulcers	☐	☐
Blood in stool	☐	☐
Change in bowel habits	☐	☐
Kidney/bladder/urine	☐	☐
Painful urination	☐	☐
Frequent urination	☐	☐

Musculoskeletal	YES	NO
Significant pain/stiffness	☐	☐
Skin	☐	☐
Rash	☐	☐
Frequent rashes	☐	☐

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NAME:_____ Date of Birth:_____ DATE:_____

Neurological	**YES**	**NO**
Tremor	☐	☐
Seizures	☐	☐
Stroke	☐	☐

Psychiatric	**YES**	**NO**
Mental Illness	☐	☐
Suicide Attempt	☐	☐
Depression	☐	☐
Drug/Alcohol addiction	☐	☐
Difficulty with sexual activities	☐	☐

Endocrine	**YES**	**NO**
Thyroid disease	☐	☐

Hematological/Lymphatic	**YES**	**NO**
Easy bruising	☐	☐

Immunologic	**YES**	**NO**
Enlarged/swollen lymph glands	☐	☐

Mark all that apply:	**YES**	**NO**
Recent weight loss	☐	☐
Low energy/fatigue	☐	☐
Double Vision	☐	☐
Eye pain	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Palpitations	☐	☐
Orthopnea	☐	☐
Chronic cough	☐	☐
Heartburn	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Blood in urine	☐	☐
Change in urinary pattern	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Tingling	☐	☐
Suicidal Thoughts	☐	☐
Trouble sleeping (insomnia)	☐	☐
Heat/cold tolerance	☐	☐
Easy bleeding	☐	☐

Additional Notes:_____

_____

_____

_____

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PATIENT CONSENT AND AUTHORIZATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

CONSENT TO TREAT

I, _____ (Patient name) give permission for Your Family Medical to give me medical treatment and I allow Your Family Medical to file for insurance benefits to pay for the care that I receive.

I understand that: ***(Please initial each)***

_____Your Family Medical will have to send my medical records information to my insurance company.

_____I must pay my share of the costs.

_____I must pay for the cost of the services if my insurance does not pain or I do not have insurance.

_____I understand that I have the right to refuse any procedure or treatment.

_____I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ **Date:** _____

Parent or Guardian Name (PRINTED): _____

Parent or Guardian Signature: _____

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PATIENT CONSENT (PHI)

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AND ANTI-DISCRIMINATION POLICY.

I, _____(Patient name), hereby state that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Novice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that, and consent to the following appointment reminders that will be used by the Practice: (a) a postcard mailed to me at the address provided by me; and (b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; (c) text message to my mobile phone.

4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees with a requested restriction, then the restriction is binding on the Practice.

6) I understands that this consent is valid for seven years. I further understand that I have the right to revoke this Consent in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

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7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

ANTI-DISCRIMINATION POLICY

Initials_____ Discrimination or harassment against any member of Your Family Medical (i.e. physicians, nurse practitioners, office staff, or patients) because of age, ancestry, color, disability as defined by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, gender, gender identity and/or expression, marital or parental status, national origin, pregnancy, race, religion, sexual orientation, veteran's status, or any other categories protected by federal or state law is prohibited and will not be tolerated, nor will any person for those reasons be excluded from the participation in or denied the benefits of any program or activity within Your Family Medical.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (PRINTED) Signature of Individual

_____ _____

Signature of Legal Representative (Attorney-in-Fact, guardian, or parent if a minor) Relationship

Date Signed: _____

Witness: _____ Title:_____

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of patient or representative

_____
Date

_____
Witness (YFM Employee) Title of Witness

List any person(s) you wish to have access to your medical information, including portal access:

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

NAME: _____ RELATIONSHIP:_____

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FINANCIAL POLICY AGREEMENT

As part of our ongoing commitment to treating our patients with complete courtesy, dignity, and respect, we regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our billing specialists prior to treatment.

INSURANCE AND PATIENT RESPONSIBILITY

Initials_____ Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copays, co-insurance payments, and deductibles for the insurance companies with whom we are contracted. YFM accepts cash, in-state personal checks, Visa, MasterCard, Discover, and American Express. There is a $30.00 service charge for returned checks.

Initials_____ I understand that if I have insurance I am the responsible party and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above. YFM bills participating insurance companies as a courtesy to our patients. Patients are expected to pay their deductible and/or co-insurance/copay at the time of service. ***You must present an insurance card at each visit. If you or your dependent(s) do not present a valid insurance card at the time of your visit, you will be responsible for the visit cost in full.***

PATIENT RESPONSIBILITY

Initials_____ I understand that some, or perhaps all of the services I receive may be non-covered or not considered reasonably necessary by my insurance company. In the event that my insurance company determines a service to be non-covered, I understand that I will be responsible for the service(s) performed. The physicians in the office will be unable to change their normal course of treatment due to non-covered services or limitations of my insurance benefits. Payment for non-covered services will be due at the time of service or upon receipt of a statement from YFM.

PAYMENT ARRANGEMENTS

Initials_____ I understand that patients with an outstanding balance of 30 days or more overdue must make payment arrangements prior to scheduling appointments. Payment plans must be set up by the patient in person and will automatically be deducted from the credit/debit card specified in that arrangement.

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MINOR PATIENTS

Initials_____ Regardless of marital status, YFM will look to the adult accompanying the patient for payment due at the time of service is rendered to the minor patient. If a parent other than the one accompanying the patient to the office is legally responsible for the account, a copy of the court decree with need to be submitted to the office. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. In addition, minor cannot receive medical treatment without the signed consent of a parent or legal guardian.

CLAIMS SUBMISSION

Initials_____ I understand that YFM will submit my claims and assist me in any way they reasonably can to help get my claims paid. I understand that my insurance company may need me to supply certain information directly to them and it is my responsibility to comply with their requests.

NON-PAYMENT

Initials_____ I understand that statement balances must be paid within 30 days to avoid late payment penalty charges. If my account is over 90 days past due, I will receive a letter stating that I have 20 days to pay my account in full. Partial payments will not be accepted unless arranged in advance with a signed payment arrangement in place. I understand that if a balance remains unpaid, YFM may refer my account to a collection agency. Any collection agency fees, in addition to my unpaid balance, will be my responsibility.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

Initials_____ I understand that if I am unable to make an appointment, I must call within 24 hours prior to your appointment time to reschedule. If I fail to notify YFM prior to missing my scheduled appointment, I understand that I will be charged a NO SHOW FEE of $25.00 for an office visit and $50 for a procedure. This must be paid prior to scheduling any future visit. Frequent missed appointments/no show, or chronic rescheduling may result in termination of physician/patient relationship and release from YFM.

Patient Signature or
Authorized Representative:_____

Printed Name of above: _____

Date: _____

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PATIENT AUTHORIZATION FOR MEDICAL DISCLOSURE (BY TELEPHONE OR FAX)

Please fill out this form and give to the Front Desk.

The patient authorizes this clinic to disclose medical information regarding clinical care and diagnoses, including laboratory results and medical history to those listed below: (i.e. family physician, referring physician, family members, attorney, etc.)

Primary Care Physician_____

Telephone _____

Name_____

Telephone _____ Relationship _____

Name_____

Telephone _____ Relationship _____

Name_____

Telephone _____ Relationship _____

I hereby request and authorize YFM to release and send the following information:

☐ Complete Record

☐ Complete Hospital Records

☐ Records from _____ to _____ only.

☐ Records concerning the following conditions only: _____

_____

This consent is in effect until revoked in writing. Our office requires patient consent in writing for all information requests not related to billing requirements.

_____ _____

Name of Patient (PRINTED) **Date**

_____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**

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SLEEP HISTORY AND EXAMINATION FORM

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Your physician requests that you complete this Sleep History Form which evaluates the need for you to have a user-friendly home sleep test. The home sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date:_____ Name:_____ Date of Birth:_____ Age:_____

Phone:_____Home Address:_____

Physician Name:_____ Height_____ Weight____lbs. BMI_____

1) Have you ever been given a CPAP device? ☐Yes ☐No (Date_____)
2) Are you comfortable with your CPAP and satisfied with its use? ☐Yes ☐No
3) How many hours do you sleep on average per night? ☐Less than 4 hrs. ☐More than 4 hours

Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale:

0 = never 1 = slight 2 = moderate 3 = high

1)	Being a passenger in a motor vehicle for 1 hour or more?	0 1 2 3 4
2)	Sitting and talking to someone.	0 1 2 3 4
3)	Sitting and reading.	0 1 2 3 4
4)	Watching TV.	0 1 2 3 4
5)	Sitting inactive in a public place.	0 1 2 3 4
6)	Lying down to rest in the afternoon.	0 1 2 3 4
7)	Sitting quietly after lunch without alcohol.	0 1 2 3 4
8)	In a car, while stopped for a few minutes in traffic.	0 1 2 3 4

Part I

1)	Have you been told that you snore or grind your teeth at night?	☐Yes ☐No
2)	Do you wake unrefreshed, tired, feeling sleepy most of the time or need to nap?	☐Yes ☐No
3)	Does your family have a history of premature death in sleep?	☐Yes ☐No
4)	Do you have diabetes?	☐Yes ☐No
5)	Have you ever been told you have coronary artery disease?	☐Yes ☐No
6)	Do you have high blood pressure?	☐Yes ☐No
7)	Have you ever experienced irregular heart rhythms?	☐Yes ☐No
8)	Do you have heart disease?	☐Yes ☐No
9)	Do you have lung disease?	☐Yes ☐No
10)	Do you suffer from depression?	☐Yes ☐No

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11) Do you take sleep medication? ☐Yes ☐No
12) Do you experience morning headaches? ☐Yes ☐No
13) Do you take sleep medication? ☐Yes ☐No
14) Do you suffer from restless leg syndrome? ☐Yes ☐No
15) Do you suffer from insomnia? ☐Yes ☐No
16) Do you suffer from narcolepsy? ☐Yes ☐No

PART II

1) Have you ever been diagnosed with sleep apnea? ☐Yes ☐No
2) Do you wake from sleep with chest pain or shortness of breath? ☐Yes ☐No
3) Has anyone said that you seem to stop breathing while sleeping? ☐Yes ☐No
4) Is your neck size larger than 15”(female) or 16.5”(male)? ☐Yes ☐No
5) Have you ever had a stroke? ☐Yes ☐No
6) Have you ever been told you have congestive heart failure? ☐Yes ☐No
7) Do you have or did you even have atrial fibrillation? ☐Yes ☐No
8) Do you wake up from sleep choking or gasping for air? ☐Yes ☐No
9) Do you wake or bother bed partner with legs kicking or moving? ☐Yes ☐No
10) Do you sleep walk, talk, or act out dreams? ☐Yes ☐No

Actual Neck Size

Patient Signature: _____ Date:_____

If patient presents with positive screening or sleep apnea a home sleep study will be ordered. ☐

Physician Signature: _____ Date:_____

Mallampati Score: _____ ☐Teeth marks on tongue ☐Overbite or recessive chin

YOUR
FAMILY MEDICAL

Agreement for medication monotoring

A proper patient-physician relationship for treatment of medication monotoring requires the physician to establish and inform the patient of the physician's expectations that are necessary for patient compliance. The following agreement explaining the patient's responsibilities is required for all patients receiving extended drug therapy for management of_____, and must be completed prior to the prescription of any controlled or dangerous medications.

1. Toxicology (drug) testing is required prior to initiation of medication therapy, and periodically while receiving therapy.

I hereby give consent for toxicology testing, and understand that refusal may lead to termination of the agreement and discontinuation of medication therapy. In addition, I understand that unexpected results on testing may require modification or discontinuation of my treatment plan. _____*(initial)*

2. Psychological and other specialty evaluations may be advised prior to or during therapy for _____. Such evaluations may be needed to ensure that treatment is safe and does not interfere with other conditions that may be present. Reasons for psychological evaluation include, but are not limited to: risk factors for substance abuse or addiction, history of substance abuse, and recent or ongoing psychiatric disorders.

I agree to follow through with all recommended psychological and specialty evaluations, and understand that refusal may lead to termination of the agreement and discontinuation of medication therapy. _____*(initial)*

3. The goal of _____ management is to provide not only _____ but to improve the overall function and quality of life for the patient. It is often not possible to provide complete relief while still optimizing the patient's overall function and quality of life. Assessment of the success of treatment will require periodic review of objective evidence that treatment goals are being met. A multi-disciplinary treatment program may be needed for optimal results.

I understand that the success of my therapy will be periodically reviewed by my physician, and that my treatment plan may be modified or discontinued if it is determined that the treatment plan is unsuccessful in achieving appropriate goals, or if objective evidence of benefit cannot be confirmed. In addition, I understand that if I do not

participate fully in an appropriate treatment plan, including non-medication treatments, my controlled medications may be discontinued as well. _____(*initial*)

4. State law requires that all prescriptions and refills for controlled drugs used in treatment and management of_____ be provided only by the primary treating physician, who will determine the number and frequency of refills. Due to the risk of adverse effects, medications should not be obtained from any other health care provider. This includes short-term prescriptions and prescriptions for pre-existing conditions or new problems that may arise while on treatment. This agreement will apply to all medications used for _____, whether for this condition or for any other.

I agree to obtain all prescriptions for _____ medications, including short-term or emergency prescriptions, only from my primary treating physician. I will not take any _____medications that have not been approved in advance by my primary treating physician. In addition, I will notify all other physicians I may see of my current medication program. _____(*initial*)

5. State law also requires that all prescriptions and refills for controlled drugs used in treating _____be obtained through a single pharmacy, which should be known to the prescribing physician.

I agree to fill all prescriptions through a single pharmacy. At any time, if my primary pharmacy changes, I will notify my physician in advance of the new pharmacy and reason for the change. My designated pharmacy is:
_____ _____(*initial*)

6. Use of other medications may interfere or interact with medications used in treatment of chronic pain. This is especially true for mood-altering medications or medications used for disorders of the nervous system (eg, seizures). In addition, illegal substances and legal but intoxicating substances (eg, alcohol) can also interact with _____medications and lead to serious or fatal events.

I agree to notify my physician of any new medications or changes to medications prescribed by other health care providers. I also agree not to use any illegal or intoxicating substances while receiving treatment for _____, and certify that I am not using illegal substances or inappropriately using any prescribed medications. _____(*initial*)

7. State law requires that the treating physician review previous evaluations for the _____ problem prior to prescribing controlled and/or dangerous substances.

I agree to provide my physician with any necessary medical records from past or present health care providers. I understand that my physician will require adequate opportunity to review my records prior to prescribing _____medications. I further understand that additional evaluations may be required prior to or during treatment.
_____(*initial*)

8. State law requires that physicians review the Prescription Drug Monitoring Program prior to and periodically during treatment for chronic pain. This is a state data base that tracks all prescriptions for controlled medications provided to a patient by any provider

and filled at any pharmacy. Drug names, quantity, prescriber, and method of payment are included in detail.

I understand that my physician will review my file in the state Prescription Drug Monitoring Program prior to and periodically during treatment. I understand that any report of prescriptions from other providers will likely lead to modification or discontinuation of my treatment plan. _____*(initial)*

9. Other requirements

- *I understand how to take my medication, and will take it **only as prescribed**.*
- *I understand that my care may be terminated at any time due to evidence or suspicion of **criminal behavior**.*
- *I understand that my treatment plan may be changed or terminated at any time by my physician if he or she determines that it cannot be continued **safely**, or if the **goals of treatment** are not being met. The treatment plan may also be changed or discontinued if the physician determines that he or she does not have the appropriate availability, staffing or support services to continue the medication safely. In such cases, a copy of the medical record will be made available to me to assist continuing care with another provider.*
- *I will **not sell or share** my medications with others, including family members and friends. I understand that it is my responsibility to ensure that my medications are not taken by others.*
- *I will **maintain control** of my medications at all times, and keep them only in a secure location. I understand that lost or stolen medications will not be replaced. I agree to ensure appropriate disposal of any unused medications.*
- *I will take my medications only for their **intended purpose**, and will not abuse them for recreational purposes. I will not store extra pills for future use, and will notify my physician of any excess supply I may have. I understand that additional refills may not be provided if I still have a supply on hand.*
- *I will notify my physician in advance of any **travel plans** or events that will require a change in my refill schedule. I understand that early refills may not be provided.*
- *I will notify my physician of any **anticipated surgeries** or other medical treatments in a timely manner to allow adjustments in the treatment plan.*
- *I understand that prescription refills will only be provided at **scheduled visits**, and I will not call between appointments or outside of regularly scheduled office hours to obtain prescription refills. I understand that it is my responsibility to schedule appointments with adequate advance notice prior to running out of medication.*
- *I agree to keep regularly scheduled follow up visits. I will notify the office in advance of any visits I am unable to attend, with adequate time to allow the appointment to be rescheduled. I understand that my pain medications may not be refilled while awaiting a **rescheduled appointment**. Further, I understand that appropriate follow up is an important safety issue, and that my pain medications may be discontinued if I miss appointments, regardless the reasons.*
- *I understand that appointments to manage my chronic pain are to be separate from appointments for other purposes. I understand that prescription refills will only be provided during appointments for which my chronic pain problem is the **primary subject of the visit**. If other medical problems need to be addressed*

during a visit, an additional visit may be required to refill chronic pain medications.

- *I authorize my physician to communicate information regarding my medical condition and treatment plan to any **other providers** who may participate in my care.*
- *I agree to treat the office staff and other patients appropriately, and I understand that **disruptive or offensive behavior** may lead to termination of the treatment plan.*
- *I agree to provide appropriate payment for medical services, and will provide the office staff with any changes in insurance coverage in a timely manner.*
- *I will notify the physician if I do not have insurance coverage for my medications, and will not pay in cash for my medications without notifying the physician in advance.*

I certify that this agreement for treatment of _____ has been adequately explained to me. I have been given adequate time to ask questions, and all my questions have been answered to my satisfaction. I further certify that at this time, I am not under the influence of any substances or medical conditions that may impair my ability to understand this agreement or consent to its provisions.

I also certify that I understand that failure to comply with all provisions of this agreement will be considered cause to modify or discontinue the treatment plan. In addition, I understand that this agreement represents the minimum requirements for obtaining controlled medications for the treatment of _____, and that additional requirements may be needed as determined by my physician or applicable regulatory agencies.

Patient signature	Printed name	Date
Reviewing staff signature	Printed name	Date
Physician signature	Printed name	Date