FLORIDA PHYSICAL MEDICINE

First Name _____ Last Name _____ Date _____

DOB: _____ Phone #:_____Age _____ Gender___ Social Security Number _____

Home Address _____ City _____ State ____ ZIP _____

Email Address _____ Marital Status ____

Height: ____ Weight: ____ Occupation: _____ Name of your primary physician_____

Date of Accident _____ Time: ____ Location of Accident _____

Were you the ◯ Driver ◯ Front Passenger ◯ Back Passenger ◯ Pedestrian ◯ On a Bicycle ◯ Other?_____

Were you struck from ☐ Behind ☐ Front ☐ Left ☐ Right? Was a citation issued to you?_____ Did the airbags deploy?___

Did another car strike you? ____ Did you strike another car? ____ Were you wearing a seatbelt? ____ Wearing a helmet?___

INJURY DESCRIPTION:_____

_____

_____

Did you hit your head? ◯ No ◯ Unsure ◯ Yes on (e.g., airbag)_____

Did you lose consciousness? ◯ No ◯ Unsure ◯ Yes Duration_____

Early Signs: ☐ Dazed or stunned ☐ Confused about events ☐ Slow to respond ☐ Dizzy ☐ Forgetful ☐ Repeating things

Are there any events just BEFORE the injury that you have no memory of (even brief)? ◯ No ◯ Yes

Are there any events just AFTER the injury that you have no memory of (even brief)? ◯ No ◯ Yes

Did you go to the hospital? ___ When (same day, 2 days)? _____ Did you go by ambulance? ____

Testing performed (e.g., Xrays, CTs, MRIs) _____Was medication prescribed?_____

Did you go to urgent care/walk in clinic?____ When_____ Was medication prescribed? _____

Have you seen anyone else for this condition? ◯ No ◯ Yes Who_____

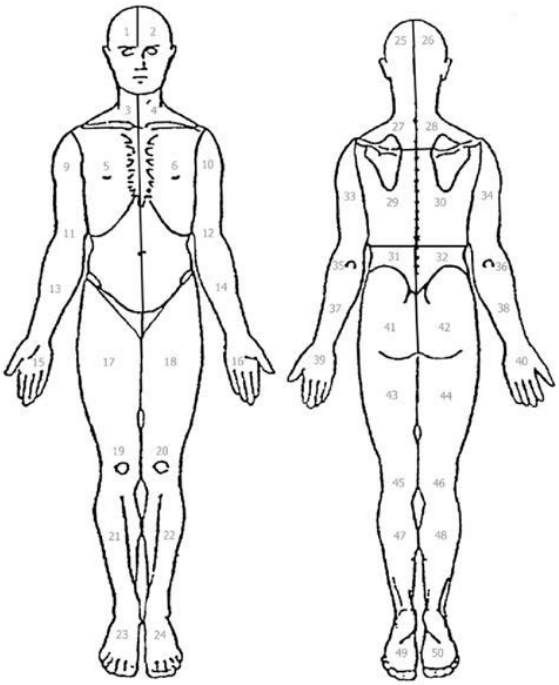
Imaging done (e.g., Xrays, MRIs) _____

Diagnoses given? _____

CURRENT SYMPTOMS:

- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Back Pain
- ☐ Back Stiffness
- ☐ Chest Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Wrist/Hand Pain
- ☐ Hip Pain
- ☐ Leg Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Numbness or Tingling (Arm)
- ☐ Numbness or Tingling (Leg)
- ☐ Numbness or Tingling (Hand)
- ☐ Numbness or Tingling (Foot)
- ☐ Muscle Tension
- ☐ Head Too Heavy
- ☐ Headache
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Sleeping Problems
- ☐ Fatigue
- ☐ Impaired Memory/Thinking
- ☐ Sensitivity to Light
- ☐ Sensitivity to Sound
- ☐ Hearing Loss
- ☐ Ringing/Buzzing in Ears
- ☐ Problems with Vision
- ☐ Mood Changes
- ☐ Nausea/Stomach Upset
- ☐ Constipation/Diarrhea
- ☐ Loss of Appetite
- ☐ Loss of Smell or Taste
- ☐ Shortness of Breath
- ☐ Sweats
- ☐ Fever

PLEASE MARK THE AREA OF PAIN ON THE DIAGRAM BELOW



Please check the words that best describe your pain.

☐ Aching ☐ Sharp ☐ Throbbing ☐ Tender ☐ Nagging ☐ Burning
☐ Numb ☐ Stabbing ☐ Localized ☐ Radiating ☐ Unbearable ☐ Exhausting

Frequency of Pain: ◯ Occasional ◯ Continuous Pain

What time of day is your pain the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

Rate your pain (on a scale from 1 to 10) by placing a number that best describes your pain at its WORST. _____

Rate your pain (on a scale from 1 to 10) by placing a number that best describes your pain ON AVERAGE. _____

What makes your pain BETTER? _____

What makes your pain WORSE? _____

Have you missed work? ◯ Yes ◯ No Explain: _____

Is your condition preventing you from participating in certain activities? ◯ Yes ◯ No Explain: _____

_____

HEADACHES? ◯ No ◯ Yes Location of headache _____

How often do you have headaches _____ How long do headaches last? _____

What does the headache feel like? ☐ Pounding ☐ Stabbing ☐ Throbbing ☐ Other _____

☐ Nausea ☐ Vomiting ☐ Sensitivity to light ☐ Sensitivity to noise ☐ Sensitivity to movement ☐ Sensitivity to smell

What medication do you take when you get a headache? ☐ None ☐ Ibuprofen (Advil) ☐ Aspirin ☐ Tylenol ☐ Naproxen (Aleve)

☐ Antihistamines ☐ Decongestants ☐ Other: _____

Prior treatment for HA? ◯ No ◯ Yes History of migraine headache? ☐ Personal ☐ Family

If you have headaches prior to the injury, how frequently did the headaches occur? _____ Migraines?_____

DIZZINESS? ◯ No ◯ Yes ☐ Spinning ☐ Light headed ☐ Balance Problems Frequency:_____

What triggers the dizziness?_____

RINGING IN EARS? ◯ No ◯ Yes Frequency:_____Details:_____

VISION PROBLEMS? ◯ No ◯ Yes ☐ Blurred vision ☐ Double vision Details:_____

Past of vision problems? ◯ No ◯ Yes If yes, please explain: _____

COGNITIVE PROBLEMS? ☐ Difficulty Concentrating ☐ Feeling mentally foggy ☐ Memory problems ☐ Feeling slowed down

☐ Fatigue ☐ Trouble multitasking ☐ Word finding troubles ☐ Other _____

Exertion: Do these symptoms worsen with: Physical Activity? ◯ No ◯ Yes Concentration/thinking? ◯ No ◯ Yes

EMOTIONAL PROBLEMS? ☐ More emotional ☐ Sadness ☐ Nervousness ☐ Irritability ☐ Excessive laughing or crying

Past history of Psychiatric or Developmental Problems? ☐ Anxiety ☐ Depression ☐ Sleep Disorder ☐ ADD/ADHD

☐ Bipolar Disorder ☐ PTSD ☐ Other psychiatric disorder ☐ Learning disabilities ☐ Other Developmental Disorder

SLEEP PROBLEMS? ☐ Drowsiness ☐ Trouble falling asleep ☐ Sleeping less or more than usual ☐ Nightmares

Have you had a prior head injury? ◯ No ◯ Yes If yes, how many times? ___

If yes, how many were diagnosed as a concussion or brain injury? ____

If yes, what, if any symptoms did you have afterwards? _____

How long did your symptoms last (e.g., 2 weeks, 6 months, etc.) _____

CURRENT MEDICATIONS: Please include all prescription, over-the-counter medications, vitamins, and herbal supplements)

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

ALLERGIES (medication, food, other): Please list and state the reaction you had: _____

HOSPITALIZATIONS / SURGERIES/ FOREIGN MATERIALS e.g., Pacemaker, metal etc. (please list procedures, dates):

_____

_____

PREVIOUS INJURIES (auto accidents, fractures, etc.):

_____

_____

PAST MEDICAL HISTORY:

☐High blood pressure ☐Heart disease ☐Diabetes ☐Mitral valve prolapse ☐Glaucoma ☐Tuberculosis
☐Liver Disease ☐Leukemia ☐Stroke ☐Hepatitis ☐HIV/ AIDS ☐Pacemaker ☐Metal implants
☐Sinusitis ☐Hemorrhoids ☐Hives ☐Bronchitis ☐Lung disease ☐Rheumatic fever ☐Kidney disease
☐Thyroid disease ☐Ulcers ☐Psychiatric disorder ☐Heart murmur ☐Colitis ☐Epilepsy ☐Cancer
☐Artificial Prosthesis ☐Mono ☐Measles ☐Mumps ☐Chickenpox ☐Whooping cough ☐Scarlet fever
☐Diptheria ☐Smallpox ☐Venereal disease ☐Anemia ☐Bladder infection ☐Migraines ☐Polio ☐Hernia
☐Blood transfusion ☐Other _____

PERSONAL HABITS: Please answer honestly. All information is confidential.
Please rate your answer on a scale of 1 to 5, with 1 being No/Never and 5 being Yes/Often.

	1	2	3	4	5	Please elaborate
Exercise Regularly (3-4 x week)	○	○	○	○	○	
Recreational Drugs	○	○	○	○	○	
Drink Alcohol	○	○	○	○	○	
Smoke/ Chew tobacco	○	○	○	○	○	
Experience Stress	○	○	○	○	○	

FAMILY HISTORY: Please check off if your relatives have had any of the following diseases.

Relatives	Arthritis	Cancer	Diabetes	Heart Disease	Stroke/ TIA	Kidney Disease	Neurological Disease	Thyroid Disease
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐

	Age	**If deceased, cause of death**
Father	____	_____
Mother	____	_____
Brothers/Sisters	____ ____ ____	_____
Children	____ ____ ____	_____

REVIEW OF SYSTEMS:

Please answer YES if you CURRENTLY have any of the following

GENERAL:

☐Allergy ☐Chills ☐Convulsions ☐Dizziness ☐Fainting ☐Fatigue ☐Fever ☐Headache
☐Sleep Loss ☐Anxiety ☐Weight Loss/Gain ☐Nervousness ☐Depression ☐Numbness ☐Tremors
☐Sweating

EYES, EARS, NOSE, THROAT

☐Asthma ☐Hearing Loss ☐Sore Throat ☐Deafness ☐Dental Decay ☐Earache/Noises ☐Ear Discharge
☐Sinus Infection ☐Enlarged glands ☐Enlarged Thyroid ☐Nose bleeds ☐Failing vision ☐Far Sighted
☐Near Sighted ☐Painful gums ☐Hoarseness ☐Nasal Obstruction

MUSCULOSKELETAL

☐Arthritis ☐Bursitis ☐Foot Pain ☐Hernia ☐Lower Back Pain ☐Lumbago ☐Neck pain/Stiffness
☐Shoulder Blade Pain

PAIN OR NUMBNESS IN

☐Shoulders ☐Arms ☐Elbows ☐Hands ☐Hips ☐Legs ☐Knees ☐Ankles ☐Feet
☐Painful Tailbone ☐Poor Posture ☐Sciatica ☐Spinal curvature

GENITO-URINARY

☐Bedwetting ☐Blood in urine ☐Frequent Urination ☐Inability to control bladder ☐Kidney Infection or stones
☐Painful Urination ☐Prostate trouble ☐Pus in Urine ☐Painful menstruation ☐Hot Flashes
☐Irregular Cycle ☐Lumps in Breasts

CARDIOVASCULAR

☐Hardening of arteries ☐High Blood Pressure ☐Low Blood Pressure ☐Pain Over Heart ☐Poor Circulation
☐Rapid Heart Beat ☐Slow Heart Rate ☐Swelling of Ankles

RESPIRATORY

☐Chest Pain ☐Chronic cough ☐Difficult breathing ☐Spitting up blood ☐Spitting up phlegm ☐Wheezing

GASTROINTESTINAL

☐Belching or Gas ☐Colitis ☐Colon Trouble ☐Constipation ☐Diarrhea ☐Heartburn/Reflux
☐Difficult Digestion ☐Distention of Abdomen ☐Gallbladder Trouble ☐Hemorrhoids ☐Excessive Hunger
☐Intestinal Worms ☐Jaundice ☐Vomiting ☐Liver Trouble ☐Vomiting Blood ☐Nausea
☐Pain over Stomach ☐Poor Appetite

WOMEN ONLY

Date of Last Period _____ Are you Pregnant? _____ Any possibility of being pregnant? _____
Do you have regular menstrual cycles? _____Cycle length _____ Do you have difficult periods? _____
Age at Menopause (if applicable): _____ Number of Children Born: _____ Have you ever had a Cesarean? _____
Describe Pregnancy Complications (if applicable): _____

FLORIDA PHYSICAL MEDICINE LLC
POWER OF ATTORNEY & MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RNEDERED, INCLUDING BUT NOT LIMITIED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint FLORIDA PHYSICAL MEDICINE LLC and any of its duly authorized agents and employees as and to be the undersigned's true an lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders are made payable for services which have been made by FLORIDA PHYSICAL MEDICINE LLC at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows FLORIDA PHYSICAL MEDICINE, LLC. or any of his agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said FLORIDA PHYSICAL MEDICINE LLC / as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to FLORIDA PHYSICAL MEDICINE LLC or any insurer providing coverage to me in connections with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.
The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

ASSIGNMENT OF BENEFITS

I _____hereby authorize my insurance company to make medical benefits payments otherwise payable to me for services rendered by any provider at any of Florida Physical Medicine locations, but not to exceed the charges of those services, payable to and mailed directly to:

Dr. Adam Didio M.D
FLORIDA PHYSICAL MEDICINE
2200 West Bay Dr., Largo, FL 33770

Furthermore, I hereby IRREVOCABLY ASSIGN to FLORIDA PHYSICAL MEDICINE, LLC. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by FLORIDA PHYSICAL MEDICINE, LLC. I also instruct the insurance carrier to request that, in the event the subject medical services and / or benefits are disputed for any reason, the amount of benefits being claimed by FLORIDA PHYSICAL MEDICINE, LLC are held in escrow and not disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned have hereunto set their hand, the _____ day of Month _____, 20_____.

_____ _____

PATIENT SIGNATURE PATIENT PRINTED NAME

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and ina **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

Adam S. DiDio, M.D.		
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, NOTICE OF PRIVACY & CREDIT CARD GUARANTEE

It is your responsibility to read the following. We will answer any questions to the best of our ability.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. You must notify our insurance department if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Signature_____ Date ____/_____/_____

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Signature_____ Date ____/_____/_____

Video Release Agreement

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that **Florida Physical Medicine** will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in **Florida Physical Medicine** policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

Patient Signature: _____

Witness: _____

Date: _____

FLORIDA PHYSICAL MEDICINE LLC
2200 West Bay Dr. Largo, FL 33770
750 94th Avenue. N., Ste. 202, St. Petersburg, FL 33702
625 6th Avenue. S., Ste. 475, St. Petersburg, FL 33701
(T) 727-518-2977 (F) 727-518-0010

Fax to: _____

Attention: _____

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

NAME OF INSURER: _____

ID NUMBER: _____

NAME OF INSURED: _____

DATE OF ACCIDENT: _____

I, _____, hereby authorize and direct MY INSURANCE COMPANY to send Florida Physical Medicine my coverage information and an accounting of payouts made under all claims submitted for payment under the above referenced policy relating to the automobile accident occurring on the above referenced date as those payouts occur.

Signature Patient _____

Patient Name: _____

Date signed _____

To Whom It May Concern,

Please be advised that I have been consulted by and have begun rendering medical treatment to the above referenced patient, with the patient's initial date of treatment occurring on _____.

In accordance with Florida Statutes 627.736 (5) (b), I will timely submit all claims to your address with mail documentation.

Truly,
Matthew Cusumano, D.O., Lora Brown, M.D., Adam Di Dio, M.D. & Brad Young R.P.T.

Florida Physical Medicine, LLC.
Phone: 727-518-2977 Fax: 727-518-0010

Letter of Protection and Authorization for Lien on Services

_____ _____
Patient Name Date of Accident

In the event that I, _____ _____, recover money from a settlement of my claim relating to the accident dated above, I direct my attorney to withhold, from my settlement, sufficient funds to pay for all medical care provided by Florida Physical Medicine, LLC, FEIN# 54-2144380, up to the lesser of a.) the funds received from the recovery of the above-named client/patient; or b.) the balance of the account, unless otherwise approved by the legal department.

My attorney will use his/her best efforts to request a confirmation of my account balance when the recovery is imminent.

If the net recovery of settlement to me is less than the total outstanding charges owed to all healthcare providers covered by a letter of protection or any other lien holder, excluding Medicare or Medicaid, Florida Physical Medicine, LLC. will have priority to have its claim paid first after attorney costs and fees.

My attorney acknowledges independent responsibility to Florida Physical Medicine, LLC. for charges incurred for medical records, medical reports, conferences and witness fees.

In the event that I am not represented by an attorney, I authorize any and all lien holders to pay directly to Florida Physical Medicine all funds due on my account related to the above-named accident.

If I, _____ _____, object to the amount of the bill, I agree that my attorney or any other lien holder to withhold an amount sufficient to pay my bill in a trust account. My attorney or any other lien holder will not thereafter pay any portion of the monies withheld, either to the doctor or to me, until a written agreement is made by all parties involved. The only exception would be upon an Order of Court of competent jurisdiction directing that such funds be paid to either me, Florida Physical Medicine, LLC.

By signing below, I have either read or have had explained to me the above written statements. By signing below, I authorize my representing attorney to protect my bills for treatment as outlined above. **I also understand and agree that I am ultimately responsible to Florida Physical Medicine, LLC for the payment of all services rendered for my benefit.**
(a copy will be accepted in place of original)

_____
Name of Representing Attorney

_____ _____ _____ _____
Signature of Client/Patient Date Witness Signature Date

_____ Patient given a copy of LOP/Lien on Services

_____ Patient denied a copy of LOP/Lien on Services

Florida Physical Medicine
2200 West Bay Dr. Largo, FL 33770

DECLINATION OF HEALTH INSURANCE

Florida Physical Medicine does not accept any form of Health Insurance. Treatment provided at our facilities will be billed directly to your auto insurance carrier.

After careful consideration, it is my decision to decline benefits available through my personal or group health insurance.

I understand that by doing so I am waiving any submission of bills from Florida Physical Medicine now, or at ay time in the future to Managed Care, Indemnity, Medicare or Private Network Health Carriers. I am aware that the reason for this is related to properly pre-approving care, timely filing limits of claims and other such industry standards and rules.

I am also fully aware that in the event of an unfavorable judgment of my personal injury matter I am personally responsible for all charges incurred in the office of Florida Physical Medicine.

Date: _____

Name: _____

Signature: _____

OFFICE AND FINANCIAL POLICY

Welcome!

At Florida Physical Medicine we take pride in providing excellent care to our patients.

We ask that our patients notify our office when there is a change of address, phone number or insurance information.

CANCELLATIONS AND NO-SHOW APPOINTMENTS:

It is your responsibility to keep or cancel your appointments. Failure to provide a 24-hour advance notice for a cancelled appointment will result in a $75.00 fee.

INSURANCE

It is the responsibility of the patient to provide the correct auto insurance to Florida Physical Medicine. We will gladly file your insurance claim with your auto insurance in a timely manner to receive payment. If the insurance company does not pay, it will be your responsibility to pay Florida Physical Medicine, LLC for all services rendered on your behalf.

PAYMENT ARRANGEMENTS:

We accept all major credit cards for your convenience.

Please read this policy carefully before signing. Our staff is happy to answer any questions you might have. Your signature certifies that you understand and will comply with this policy.

Patient's Signature: _____ Date: ___/___/___

Controlled Substances Therapy for Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefits. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential of abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

_____**(Males Only)** I am aware the chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

_____**(Female Only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to deliver while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____ Phone: _____
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substance may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with the chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, et. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.
13. Prescriptions may be issued early if the physician or patient will be out town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation.)
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this for voluntarily, I give my consent for the treatment of my pain with controlled substances including but not limited to opioid pain medicines.

_____ _____

Physician Signature Patient Signature

_____ _____

Date Patient Name (Printed)