DESERT PAIN AND REHAB SPECIALISTS

FACT SHEET AND CONSENT FOR CONSULT VISIT FOR CHRONIC PAIN WITH POSSIBLE TREATMENT WITH CONTROLLED SUBSTANCES

Since other treatments have not worked well to control your pain, should you meet our practice criteria, we will discuss the option of placing you on a trial of opioids to help manage your pain and to improve your social and work activities. This is a serious decision. Please note: you may or may not be placed on opioids. Even when using opioids, you should not expect your pain to be completely gone. This type of treatment does have risks. The most common of which are listed below:

1. Constipation can occur with all opioids and a daily laxative such as Senna, aloe vera capsules or a prescription medication such as Mira lax is recommended. Avoid bulk forming laxatives like Metamucil.
2. Confusion or change in thinking abilities can occur from the breakdown products of some opioids.
3. Problems with coordination or balance may make it unsafe to operate equipment or motor vehicles during the first few days of treatment or for a few days after a dose increase. This is usually temporary.
4. Increased sleepiness or drowsiness (SAME AS ABOVE).
5. Overdose, which can lead to death by breathing too slowly.
6. Physical dependence - this means that abrupt stopping of the drug may lead to withdrawal symptoms such as runny nose, diarrhea, abdominal cramps, aches, "gooseflesh", and anxiety. This withdrawal syndrome is **NOT** life-threatening but can be very uncomfortable and may last for a few days. Physical dependence is different than the disease of addiction which, like alcoholism, is characterized by a loss of control over the substance and a psychological craving to continue using even when the use of the medication is causing your quality of life to worsen rather than improve. True addiction is very rare, probably less than 5%, in patients using opioids for pain and usually occurs in people who have had previous problems with drugs or alcohol, or have a strong family history of these problems.
7. Tolerance- (needing more of the drug to get the same effect) usually occurs very slowly in most pain patients.
8. Children born to mothers on these substances can be physically dependent on the drug at birth and may need to stay in the hospital a few days longer for detox. There is no evidence that opioids cause birth defects.
9. Decrease in testosterone and estrogen leading to menstrual irregularities or problems with sexual function. These can usually be treated with hormone therapy.
10. Dry mouth may cause dental decay.
11. Nausea, itching, and sweating are common and usually temporary side effects.
12. Other less common side effects and risks are possible.

Any medical treatment is initially a trial. This visit is an initial consult to determine you r eligibility to be prescribed opioids and this will occur only if there is evidence of benefit.

You agree to have unannounced blood or urine tests and/or pill counts to assess your initial qualification as we; as compliance with the treatment program. These will be completed within 24 hours of notification. Presence of unauthorized substances will result in discharge from treatment and/or referral to other providers.

You also agree to released me (your physician) or any employee of Desert Pain and Rehab Specialists from any and/or any claims or actions arising from or in connection with urine drug screens/ pill counts, release of results to those for whom you have given consent and/or for any lawful use of such results.

Your signature below verifies that you have read this document and it entirety, understand it, and have had all your questions answered satisfactorily. You consent to the use of opioids to help control your pain, and understand that treatment will be carried out in accordance with the conditions stated above.

____
Patient name (printed)

______________________________ ______________________
Patient signature Date

______________________________ ______________________
Physician signature Date

DESERT PAIN AND REHAB SPECIALISTS

11047 N. 19TH AVE PHOENIX AZ 85029 PH: 602-944-2222 FAX: 602-331-2499

HIPPA CONSENT

For your convenience, in the event that our office is unable to contact you regarding information related to your healthcare, you allow our office to relay this information either to a spouse, relative or friend listed below:

I, ______________________________, consent to DESERT PAIN AND REHAB SPECIALISTS and/or its representatives to discuss my protected health information with ______________________. My relationship with this person is that of ______________________ Please note any exceptions: __________________

OPTIONAL: May we leave a message on your answering machine or voice mail?

YES ________ NO ________

PLEASE PROVIDE AT LEAST TWO CONTACT PHONE NUMBERS FOR OUR CONVENIENCE:

1.) ______________________ 2.) ______________________

SIGNATURE: ______________________________ **DATE:** ________________

I REVOKE THE ABOVE AUTHORIZATION EFFICTIVE: ________________________

COMMENTS: ____

____

OPTIONAL:

AT TIMES OUR PRACTICE IS INFORMED OF VARIOUS CLINICAL TRIALS THAT ARE BEING CONDUCTED FOR NEW INVESTIGATIONAL DRUGS. IF YOU WOULD LIKE YOUR HEALTH INFORMATION MADE AVAILABLE AND BE CONTACTED REGAURDING THESE TRIALS, PLEASE PROVIDE CONSENT BELOW:

SIGNATURE: ______________________________ DATE: ____________________

DESERT PAIN AND REHAB SPECIALISTS
11047 N. 19th AVE, Phoenix, AZ 85029
PATIENT DEMOGRAPHICS

PLEASE PRINT AND ANSWER COMPLETELY:

DATE: ______________________ SOCIAL SECURITY #: ______ - ______ - ________ CIRCLE: MALE/ FEMALE
NAME: ____ DATE OF BIRTH: __________________
ADDRESS: ____________________________ CITY: ____________ STATE: ________ ZIP: _________
HOME PHONE: __________________________ WORK PHONE: ______________________________
CELL PHONE: __________________________
PRIMARY CARE DR: ___________________________ PHONE: ____________________________

PARENT OR SPOUSE INFO:

PARENT/SPOUSE NAME: ______________________________ PHONE: _________________________

INSURANCE INFO:

PRIMARY: ____________________________ PHONE: _________________________
INSURANCE ADDRESS: _________________________ CITY: ________ STATE: _______ ZIP: _________
ID#: ________________ GROUP: _________________________ COPAY/DEDUCT? ___________
INSURED NAME: _________________________ DOB: ____________ SS#: _______ - ____ - _______
RELATIONSHIP: _______________________ INSURED'S EMPOLYER: ___________________________

INDUSTRIAL/WORK COMP INFO (IF ALL INFO IS NOT SUPPLIED BE AWARE YOU WILL BE BILLED FOR SERVICES):

EMPLOYER NAME: _________________________ WORK PHONE: ___________________________
INDUSTRIAL INJURY: YES/ NO DATE OF INJURY: _________ TYPE OF INJURY: ____________________
INDUTIAL INSURANCE NAME: _____________________ CLAIM #: ______________________________
ADDRESS: _____________________ CITY: ______________ STATE: __________ ZIP: ___________
PHONE: ____________________ NAME OF CASE MANAGER: ____________ FAX #: ______________
NAME OF INDUSTRIAL ATTORNEY: ____________________ PHONE: __________________

EMERGENCY INFORMATION:

NAME OF RELATIVE NOT LIVING WITH YOU: _______________________ PHONE: __________________
RELATIONSHIP: _______________________ YEARS KNOWN: ____________________
ADDRESS: _______________________ CITY: ____________ STATE: ____________ ZIP: ____________
REFERRED BY: ____

INSURANCE ASSIGNMENT & AUTHORIZATION FOR TREATMENT:

I HEREBY AUTHORIZE THE ABOVE INSURANCE COMPANY TO PAY ANY MEDICAL BENEFITS AVAILABLE INDER MY POLICY DIRECTLY TO DESERT PAIN AND REHAB SPAECIALISTS, PLLC. I AGREE THAST PAYMENT WIL NOT BE DELAYED/WITHHELD DUE TO INSURACE/CLAIM DELAYS OR FOR NONPAYMENY BY INSURANCE COMPANY. I AGREE THAT ALL PROCEEDS OF INSURANCE ARE ASSIGHNED TO THIS OFFICE WHERE APPLICABLE. I FURTHER AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT MYSELF TO RELEASE TO MY INSUANCE CARRIER OR ITS AGENTS ANY INFORMATION THAT MAY BE NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE UNDER THIS POLICY. I FURTHER ALLOW THE RELEASE OF ANY INFORMATION THAT MAY BE NECESSARY TO FILE <u>ANY</u> CLAIMS BEING HANDLEDBY OUR BILLING DEPARTMENT. FURTHERMORE I AUTHORIZE DESERT PAIN AND REHAB SPECIALISTS AND ITS MEDICAL PROVODERS, EMPLOYEES OR I NDEPENDENT CONTRACTORS TO PROVIDE MEDIAL CARE, PERFORM THERAPEUTIC/DIAGNOSTIC PROCEDURES NEDESSARY TO MY TREATMENT, IN THEIR JUDGEMENT, WHICJ MAY INCLIDE BUT NOT LIMITED TO PHYSICAL THERAPY, ACUPUNCTURE, INJECTIONS, THERAPEUTIC.DIAGNOSTIC STUDIES OR ANY METHOD WHICH IN THE DOCTORS JUDGEMENT MAY ASSIST IN PROVIDING AND MONITORING MY MEDICAL CARE.

____
SIGNATURE PRINT NAME DATE

DESERT PAIN AND REHAB SPECIALISTS, PLLC
11047 N. 19TH AVE
PHOENIX AZ 85029
PH; 602-944-2222 FAX: 602-331-2499

NOTICE OF PRIVACY-PRACTICES

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

If you have any questions about this Notice or would like to receive a complete copy of our Privacy policy please contacts our privacy officer Stacy Ross at the above address and phone number.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information are based Upon Your Written Consent to Treatment, Payment, healthcare Operations.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. 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.

Other Permitted and Required Uses and Disclosures that may be with your Consent, Authorization, or opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may use professional judgement to determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare

Emergencies, communication Barriers, treating physicians, pharmacies, ancillary services, business associates, Billing Department utilized by Desert Pain and Rehab Specialists and affiliated practices or insurance carriers.

Other Permitted and Required Uses and Disclosures that may be without your Consent, Authorization, or Opportunity to Object

We may use or disclose your protected health information to the following situations without your consent or authorization:
As required by Law, Public Health agencies, communicable disease, health oversight, abuse or neglect, food and drug administration, Legal Proceedings, Law Enforcement, coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, military Activity, National Security, Workers' Compensation, and Correctional Departments (If you are an inmate), required Uses and Disclosures.

Your Rights

You have the right to inspect a copy of your protected Health Information.
You have the right to request a restriction of your Protected Health Information. (Request with our officer).
You have the right to request to receive confidential communications from us be alternative means or at an alternative location.
You have the right to request to have your physician amend your Protected Heath Information.
You have the right to receive an accounting of certain disclosures we have made of your Protected Health information.
You have the right to obtain a paper copy of this notice from us.

Complaints

You may contact our Privacy officer, Stacy Ross, at the above Address and phone number for further information about the complaint process.

Print Name: ______________________ Signature: ______________________

Personal representative (If Any): ______________________ Date: ____________

Description of Personal Representative's Authority (POA): ______________________
POA on File? ______________________

This notice was published and becomes effective on March 10, 2016

OPIOD RISK TOOL (ORT)

Patient Form

Name: ______________________________ Date: ____________________

Mark Each Box that applies If none pertain to your history, put NA		Female	Male
1. Family history of substance abuse i.e. Mother and/or Father	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box IF 16-45 years old)			
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	• Attention-deficit/hyperactivity disorder • Obsessive compulsive disorder • Schizophrenia • Depression	[ ] [ ] [ ] [ ]	[ ] [ ] [ ] [ ]

Desert Pain and Rehab Specialists

CURRENT MEDICATIONS

PLEASE LIST **ALL** MEDICATIONS AND DOSES

PATIENT ______________________ DATE ______________

MEDICATION	STRENGTH/DOSE	DIRECTIONS

DESERT PAIN AND REHAB SPECIALISTS

11047 N. 19TH AVE

PHOENIX AZ 85029

PATIENT ALLERGIES LIST

PATIENT: ______________________________ D.O.B. ____________________

Please list ALL medication allergies and you reaction to the medication below:

Medication: Reaction:

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

Patient Signature: ______________________________ Date: ____________________

DATE: ____________________

NAME: ____________________ AGE ________

CURRENT PROBLEM: ____________________

DATE OF INJURY ____________________

FIRST DATE OF SYMPTOMS ____________________

HOW IT OCCURRED ____________________

____

____

Pain drawing and scale review

1. Shade the area of your pain.
2. Place an "X" at the worst area(s) of pain.

On a scale of 0-10

What is the level of the worst pain you have?

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 **(EXCRUCIATING)**

What is the level of pain you have MOST of the time?

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 **(EXCRUCIATING)**

PAST MEDICAL HISTORY- MAJOR ILLNESSES

	YES	NO	ACTIVE?
DIABETES			
CANCER			
STOMACH ULCER			
HIGH BLOOD PRESSURE			
HEART ATTACK			
HEART PROBLEM			
EMPHYSEMA			
BRONCHITIS			
NEUROLOGIC DISEASE/INJURY			
CVSTROKE			
BLEEDING DISORDER			
THYROID DISORDER			
INFECTIONS-TB			

PLEASE LIST OTHER CHRONIC ILLNESSES:

____

____

____

PAST TESTS:	YES	NO	WHAT YEAR?
XRAYS:			
CT SCANS:			
MRI:			
EMG:			
BONE SCAN:			
BLOOD TESTS:			
OTHER:			

OPERATIONS	DATE DONE

OTHER HOSPITALIZATIONS	DATE DONE

DRUG ALLERGIES	DATE DONE

SOCIAL/PERSONAL HISTORY

OCCUPATION: ____________________

ARE YOU CURRENTLY WORKING? ____________________

MARITAL STATUS ____________ CHILDREN ________

DO YOU SMOKE? YES ( ) NO ( ) DATE QUIT: ____________

ARE YOU PREGNANT? YES ( ) NO ( )

LAST MENSTRUL PERIOD DATE: ____________

FAMILY MEDICAL HISTORY	MAJOR ILNESSES
FATHER/LIVING YES ( ) NO ( )	
MOTHER/LIVING YES ( ) NO ( )	
SIBLINGS: # OF BROTHERS ____	
# OF SISTERS ____	

SYSTEM REVIEW-Please check ANY of the following you may have had over the past year.

	Y	N		Y	N
FEVER			JOINT PAIN		
CHILLS			MORNING STIFFNESS		
NIGHTS SWEATS			SWELLING		
WIEGHT LOSS			SKIN DISORDER		
DOUBLE VISION			WEAKNESS		
BLURRY VISION			NUMBNESS/TINGLING		
HEARING LOSS			DIZZINESS		
SHORT OF BREATH			DEPRESSION		
COUGH			ANXIETY		
COUGHING BLOOD			ALCOHOLISM		
STOMACH ULCERS			ILLEGAL DRUG USE		
BLOOD IN STOOL			THYROID DISEASE		
DIARRHEA			ANEMIA		
CONSTIPATION			ABNORMAL BLEEDING		
LIVER DISEASE			ALLERGIES		
KIDNEY/BLADDER INFECTION			BLADDER/BOWEL INCONTINENCE		

REVIEWED: ____________________

DATE: ____________

Desert Pain and Rehab Specialists

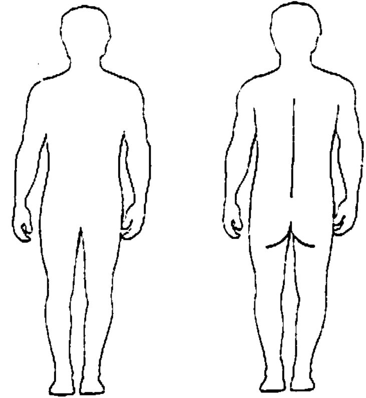
Name________________________________ DOB________________

Pain Questionnaire

1. Where is your pain? Write in words or use the picture to show where you have pain.

____

____



2. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

3. Does your pain occur occasionally, frequently or is it constant? (Circle one)

   Occasionally   Frequently   Constant

4. What time of day is your pain the worst? (Circle one)

   Morning   Afternoon   Evening   Nighttime

5. Rate your pain by circling the number that best describes your pain at its **worst** in the last month.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain at its **least** in the last month.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. Rate your pain by circling the number that best describes your pain on **average** in the last month.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

8. Rate your pain by circling the number that best describes your pain **right now**.

   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Pain History Form continued on reverse...

9. What makes your pain **better**? ______________________________

10. What makes your pain **worse**? ______________________________

11. What treatment or medication are you receiving for your pain? If you are not receiving any treatment or medication, circle NONE.

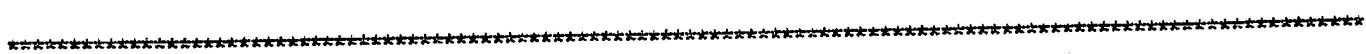
    None

    ____

12. Circle the one number that describes how, during the past week, pain has interfered with your:

a. General Activity	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
b. Mood	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
c. Normal Work	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
d. Sleep	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
e. Enjoyment of life	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
f. Ability to concentrate	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes
g. Relationships with other people	Does Not Interfere	0 1 2 3 4 5 6 7 8 9 10	Completely Interferes

Patient Signature ______________________________ Date: ___/___/____



Notes:

☐ No action plan required.

☐ Action plan required. See progress note.

Provider Signature ______________________________ Date: ___/___/____

DESERT PAIN & REHAB SPECIALISTS
FACT SHEET AND CONSENT FOR TREATMENT OF CHRONIC PAIN WITH CONTROLLED SUBSTANCES
OPIOID CONTRACT

Since other treatments have not worked well to control your pain, I have discussed the option of placing you on a trial of opioids to help manage your pain and to improve your social and work activities. This is a serious decision. Even when using opioids, you should not expect your pain to be completely gone. This type of treatment does have risks. The most common of which are listed below:

A

13. Constipation can occur with all opioids and a daily laxative such as senna, aloe vera capsules or a prescription medication such as Miralax is recommended. Avoid bulk forming laxatives like Metamucil.
14. Confusion or change in thinking abilities can occur from the breakdown products of some opioids.
15. Problems with coordination or balance may make it unsafe to operate equipment or motor vehicles during the first few days of treatment or for a few days after a dose increase. This is usually temporary.
16. Increased sleepiness or drowsiness (SAME AS ABOVE).
17. Overdose, which can lead to death by breathing too slowly.
18. Physical dependence - this means that abrupt stopping of the drug may lead to withdrawal symptoms such as runny nose, diarrhea, abdominal cramps, aches, "gooseflesh", and anxiety. This withdrawal syndrome is **NOT** life-threatening but can be very uncomfortable and may last for a few days. Physical dependence is different than the disease of addiction which, like alcoholism, is characterized by a loss of control over the substance and a psychological craving to continue using even when the use of the medication is causing your quality of life to worsen rather than improve. True addiction is very rare, probably less than 5%, in patients using opioids for pain and usually occurs in people who have had previous problems with drugs or alcohol, or have a strong family history of these problems.
19. Tolerance- (needing more of the drug to get the same effect) usually occurs very slowly in most pain patients.
20. Children born to mothers on these substances can be physically dependent on the drug at birth and may need to stay in the hospital a few days longer for detox. There is no evidence that opioids cause birth defects.
21. Decrease in testosterone and estrogen leading to menstrual irregularities or problems with sexual function. These can usually be treated with hormone therapy.
22. Dry mouth may cause dental decay.
23. Nausea, itching, and sweating are common and usually temporary side effects.
24. Other less common side effects and risks are possible.

Any medical treatment is initially a trial. Continued prescribing will occur only if there is evidence of benefit. I am willing to begin or continue treatment for you with narcotics (opioids) and/or sedatives (i.e. SOMA, Xanax, Valium, Restoril, etc) under the following set of conditions:

B.

1. Other reasonable forms of treatment have not been effective or have produced too many side effects.
2. You will obtain all prescriptions for narcotics from me, except from any Emergency Room in which case you win list me as your treating physician.

3. You will **take your medications only as prescribed**, and under no circumstances, allow other individuals to take your medications or take anyone else's medications. You understand that if you use your medication at a faster rate than prescribed, and do not call for permission to do this before you do it, you will run out of your medications early and be without medications for a period of time. You are likely to be sick from narcotic withdrawal if this occurs.
4. I have permission to discuss any details of your treatment with dispensing pharmacists or other professionals who provide your healthcare for purposes of maintaining accountability.
5. All controlled substances will be obtained at **ONE** pharmacy where possible. If you change pharmacies, you will need to notify our office immediately.
   PHARMACY: ______________________ PH# or cross streets: __________________
6. You will follow my advice in regards to stopping these controlled substances if that is advised.
7. You agree to have **unannounced** pill counts, blood and/or urine tests to assess your compliance with the treatment program. These will be completed within **24** hours of notification. Presence of unauthorized substances, misuse and/or being short of medications may result in **DISCHARGE** from treatment and/or referral to other providers. You also agree to release me (your physician) or any employee of Desert Pain & Rehab Specialists from any claims or actions arising from or in connection with urine drug screens/pill counts, release of results to those for whom you have given consent and/or for any lawful use of such results.
8. If you are a female of childbearing potential, you certify that you are not pregnant, and that you will use appropriate measures to prevent pregnancy during treatment with opioids.
9. You will keep all scheduled appointments and may be charged a fee for **missed** or **late** cancelled appointments. Prescription renewals **may be denied** if appointments are missed.
10. You understand that medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If they are stolen, and a police report is made, an exception may be made. However, since these medications may be sought by individuals with addiction problems they should be closely safeguarded. They should not be left where others (family, friends, or others who enter your home) might have access to them. In addition, when traveling, only take the amount you need plus a little extra. Do not carry your entire bottle with you. Have a safe place at home, maybe even a lock box or safe, and carry a small amount on your person for day to day use. Use a small pill-box or even an old bottle with your name, name of the medication, and prescribing physician on it.
11. You will remain abstinent from all other mood altering substances unless I authorize use of these. Mood altering substances include, but are not limited to: alcohol, stimulants (such as cocaine & amphetamines) sedatives, and marijuana. Ask first if you are unsure about any medications you are prescribed that fall into one of these categories.
12. You will attend a 12-step recovery program if indicated, which includes:
    a.________________ b.__________________ c.________________
13. You understand that this plan of treatment will be stopped if any of the following occur:
    A. I feel that opioids are not effective for your pain, or that your functional activity has not improved.
    B. You give, sell, or misuse the medication we prescribe.
    C. You develop rapid tolerance or loss of effect from this treatment.
    D. You develop side effects that are significant.
    E. You obtain opioids from another source that has not been authorized.
14. Refills of controlled substances will be made ONLY during regular business hours, 9 AM-5:00PM, Monday thru Thursday, and 9 AM-12 PM on Fridays. REFILLS WILL NOT BE MADE AT NIGHT OR ON WEEKENDS.
    Early refills will generally **not** be given. Prescriptions may be written early if the patient is going out of town, proof may be required (i.e. Plain ticket receipt, gas receipt etc.) . This may require prior authorization from your insurer.

15. You understand that it is your responsibility to keep yourself and others from harm that may be caused by your medications. This means not driving or operating heavy machinery until you are stable on your dose and not feeling sedated or impaired in any way. Since these medications may be hazardous to others, especially children, who are not tolerant to them, you must keep them out of reach of such people.
16. You understand that any rude, hostile or aberrant behavior towards staff or any other patient will cause for an IMMEDIATE DISCHARGE from our practice, this behavior is unacceptable and not welcome.

If I choose to discontinue your opioids, the dose will generally be lowered slowly. If I feel that you have a problem with opioid addiction/dependence, I may refer you for more intensive management of that problem including hospitalization for detox or methadone maintenance.

Your signature below verifies that you have read this document, understand it, and have had all your questions answered satisfactorily. You consent to the use of opioids to help control your pain, and understand that treatment will be carried out in accordance with the conditions stated above.

______________________________ ________________
Patient Name (PRINT) Date

____
Patient Signature

______________________________ ________________
Physician Signature Date