RPCC PATIENT DEMOGRAPHICS (PD)

Name: ____
Last First MI

Address: ____
City State Zip

Home#: ____________________ Work#:__________________ Cell#:________________________

DOB: ____/___/___ SS#: ___________Marital Status: S / M / D / W Male/Female (circle)

Race: American Indian____ Alaskan____ Asian____ Black____ Caucasian____

Emergency Contact: ____
Name Number Relation to Patient

Referring Physician: ____
Name Number

Primary Care Physician (Required): _______________________________________
Name Number

INSURANCE INFORMATION: <u>(If you are working, Medicare is your Secondary)</u>

Primary Insurance

Insurance Company: ____________________________________ Phone#: _____________________

ID#: _________________________________ GRP#: ______________________

Subscriber Information if not **SELF**

Name: ____________________________________ SS#:_______________ DOB: ___________

Subscribers' Employer: ____

Secondary Insurance

Insurance Company: ____________________________________ Phone#: _____________________

ID#: ________________________________ GRP#: ______________________

Subscriber Information if not **SELF**

Name: ___________________________________ SS#: ______________ DOB: ___________

Subscribers' Employer: ____

Acknowledgement of Review of Notice of Privacy Practice

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.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be used in place of the original. I understand *<u>I am financially responsible</u>* to the center for charges not covered or that are denied by my insurance company. I further agree in the event of non-payment, to pay the cost of collection and/or court cost and reasonable fees, should this be required.

By signing below I also give permission for **Regional Pain Care Center** to access my pharmacy benefits data electronically through **RelayHealth.** We ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using **RelayHealth**.

____
Signature of Patient or Personal Representative Date

____
Name of Guardian/Representative Relation to Patient Date

____
Witness Date

PAST MEDICAL HISTORY (PMH)

Do you currently have or do you have a history of any of the following:

___ High blood pressure
___ Heart disease
___ Angina
___ Chest Pain
___ Irregular heartbeat
___ Rheumatic fever
___ Mitral Valve Prolapse
___ Stroke
___ Easy bruising
___ Hemophilia
___ Bleeding tendency
___ Arthritis
___ Anemia
___ Neck Pain/Stiffness
___ Spinal Cord Stimulator

___ Thyroid disease
___ Mental Illness
___ Migraine headaches
___ Fainting
___ Seizure disorder
___ Blood transfusion
___ Leg cramps/pain
___ Varicose vein
___ Chemical Dependency
___ Diabetes
___ HIV
___ Liver Disease
___ Cataracts
___ Multiple Sclerosis
___ Pacemaker

___ Hepatitis
___ Vision Disorder
___ Jaundice
___ Back Injury
___ Neck Injury
___ Herniated Disc
___ Steroid Use
___ Ulcer
___ Frequent Heartburn
___ Hiatal Hernia
___ Cancer
___ Chemotherapy
___ Glaucoma
___ TB

___ Sinusitis
___ Bronchitis
___ Shortness of Breath
___ False teeth/Caps
___ Hoarseness
___ Recent Cold
___ Asthma
___ Motion Sickness
___ Loose Teeth
___ Sexual Transmitted Disease
___ Emphysema
___ Chronic Cough
___ TMJ

List any medical problems not listed above:
____
____
____

___ Tobacco Amount: ___ Packs/day for ___ years
___ Alcohol Amount: ____________________________
___ Street/Recreational Drugs: Types: _______________

List all previous surgeries:_______________
____
____
____
____

Problems with Anesthesia: ☐ Yes ☐ No

☐ High Temperature ☐ Muscle Spasms
☐ Allergic Reaction ☐ Jaundice
☐ Delayed Awakening ☐ Headache
☐ Prolonged Weakness ☐ Nausea and Vomiting
☐ Difficulty with breathing tube ☐Excessive Bleeding

☐ NO KNOWN DRUG ALLERGIES

Allergies: Name Reaction | Name Reaction

1.____ 2.____

3.____ 4.____

Height ______Weight _________

Immunizations Current? ☐ Yes ☐ No

Chief Complaint/Reason for Visit:____

Highest Level of Education ____________________________
Do you have any cultural/religious practices that will impact your health care? ☐ Yes ☐ No
If yes, Please explain.____

AUTHORITY TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of the information contained in my medical records to: (Example: family member and or a physician)

Name/phone number or fax number:____

I understand that my medical records may contain information that indicates that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

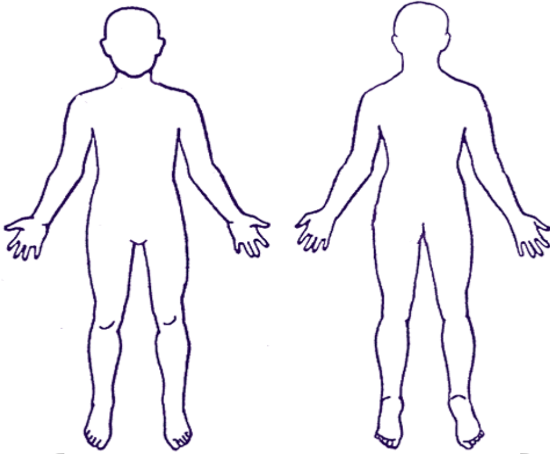
With this knowledge, I give my consent to the release of all information in my medical records including and any information concerning my identity and release provider, its agents, and employees from any liability in connection with the release of information contained therein.

PATIENT NAME (PRINT) SIGNATURE DATE

PAIN MANAGEMENT QUESTIONNAIRE (PMQ)

PATIENT NAME____ DATE______________________

REFERRING PHYSICIAN____________________________________ DATE PAIN STARTED____________



PLEASE INDICATE WHERE YOUR PAIN OCCURS BY SHADING IN PAINFUL AREAS

Please indicate by circling:

YOUR PAIN AT THE PRESENT TIME: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AT ITS WORST: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AS ITS LEAST SEVERE: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AS IT USUALLY IS: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

SINCE YOUR PAIN BEGAN, HAS IT: Increased Decreased Stayed the same

HAVE YOU HAD ANY OF THE FOLLOWING?

- ❑ X-RAYS
- ❑ MYELOGRAM/DISCOGRAM (CIRCLE ALL THAT APPLY)
- ❑ EMG
- ❑ CAT SCAN
- ❑ EMERGENCY ROOM VISITS
- ❑ MRI SCAN
- ❑ BONE SCAN
- ❑ PHYSICAL THERAPY
- ❑ TENS UNIT for pain
- ❑ NERVE BLOCKS (INJECTIONS) FOR PAIN RELIEF.

PHYSICIAN THAT PERFORMED BLOCKS:

WHICH STATEMENT BEST DESCRIBES YOUR PAIN?

(Choose One)

- ❑ Always present, always the same intensity.
- ❑ Always present, intensity varies.
- ❑ Usually present, but have short periods without pain.
- ❑ Often present, but have pain free periods lasting one to several hours.
- ❑ Often present, but am pain free most of the day.
- ❑ Occasionally present. Have pain once to several times per day, lasting a few minutes to an hour.
- ❑ Occasionally present for brief periods, a few seconds to a few minutes.

DO ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL WORSE? (Check all that apply)

- ❑ Coughing, Sneezing
- ❑ Sitting
- ❑ Standing
- ❑ Lying Down
- ❑ Walking
- ❑ Physical Activity
- ❑ Sexual Activity
- ❑ Other:_________

WOULD YOU DESCRIBE YOUR PAIN AS..?

- ❑ Burning
- ❑ Sharp
- ❑ Throbbing
- ❑ Shooting
- ❑ Aching
- ❑ Other:___________________

WHAT TIME OF DAY IS YOUR PAIN WORSE?

- ❑ Morning, On Arise
- ❑ Later in the morning
- ❑ Afternoon
- ❑ Evening
- ❑ Bedtime
- ❑ Night (During usual sleep hours)
- ❑ Pain is always the same
- ❑ Pain varies, But is not worse at any particular time

DO ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL BETTER? (Check all that apply)

- ❑ Relaxation
- ❑ Sitting
- ❑ Standing
- ❑ Lying Down
- ❑ Alcoholic Drinks
- ❑ Sexual Activity
- ❑ Heat
- ❑ Medicines
- ❑ Walking
- ❑ Other:___________________
- ❑ Nothing Makes Me Feel Better

DO YOU HAVE ANY OF THE FOLLOWING?

(Check all that apply)

- ❑ Numbness
- ❑ Tingling (Pins and Needles)
- ❑ Weakness
- ❑ Coldness
- ❑ Increased Sweating
- ❑ Muscle Spasm, Tightness
- ❑ Skin Discoloration
- ❑ Bowel or Bladder Problems

DOES PAIN INTERRUPT YOUR SLEEP?

❑ YES ❑ NO

SLEEPING TROUBLE:

- ❑ Never (0 times a month)
- ❑ Seldom (4 times a month)
- ❑ Occasionally (5 times a month)
- ❑ Often (10 times a month)
- ❑ All the time (Every night)

WAKENING TROUBLE:

- ❑ Never (0 times a month)
- ❑ Seldom (4 times a month)
- ❑ Occasionally (5 times a month)
- ❑ Often (10 times a month)
- ❑ All the time (Every night)

Regional Pain Care Center

1111 Raintree Circle Suite 170
Allen, TX 75013
214-509-9691

MEDICATION LIST

Patient Name: ____

Doctor you are seeing: ____

Are you here for MRI/CT results ? Yes or No Date of last injection: _______________________

DID YOU BRING YOUR MEDICATION BOTTLES WITH REMAINING PILLS?

List of Medications (include over the counter) Dosage Times per day

____
____
____
____
____
____
____

On the average, how severe has your pain been during the last week?

0 1 2 3 4 5 6 7 8 9 10

Not severe at all Extremely severe

In general how much is you pain interfering with day-to-day activities?

0 1 2 3 4 5 6 7 8 9 10

Release of information and assignment of benefits:
I heareby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be sed in place of the original. I understan *I am financially responsible* to the center of charges not covered or denied by my insurance compnay. I further agree in the event of non-payment, to pay the cost of collection and/or court cost and reasonable fees, should this be required.

Signature: ____________________________________ Date: ______________________

NOTICE TO ALL PATIENTS

- Effective January 1, 2014 any and all deductible/co-insurance will be due at the time of your visit.

- Please remember to bring your medication bottles that our doctors prescribe you to each appointment.

- It is the patient's responsibility to supply a medication list or we can copy **your** list for you at each visit (we will not be able to print it for you).

- Prescription Prior Authorizations:
  Due to the time and effort that is required for prescription prior authorizations there will be a non-refundable $50.00 charge for each prescription authorization that needs to be obtained by the physician. There are no guarantees that your insurance company will approve the prior authorization.

____

Printed Name Signature Date

RPCC Pharmacy PI

PLEASE TAKE A MOMENT AND READ THE FOLLOWING INFORMATION REGARDING OUR OFFICE REQUIREMENTS/POLICIES

We ask that you complete paperwork and present you INSURANCE CARD and DRIVER'S LICENSE if you are the patient or the parent of a patient who is a minor. If the patient is a minor, a parent or legal guardian must accompany the child. Legal guardians should bring a copy of the Consent to treat form or the child cannot be treated.

EVERY NEW PATIENT must bring medical records (pertaining to their current problem) to the first appointment. Past medical history, X-rays, CT scans, MRI's, lab reports and a list of their medications.

As a courtesy to our patients, we will file your insurance claims; however, you are required to bring your CURRENT INSURANCE CARD and drivers. If you do not have you insurance card or driver's license, payment in full will be due on the date of service, or we can reschedule your appointment. Patient should know their benefits and limitations before coming to the office. We are not responsible for knowing every policy that is on the market.

If your insurance company requires a referral from your Primary Care Physician, it is YOUR RESPONSIBILITY to obtain it. If you do not have your referral with you or one is not in the system at the time of your appointment, you will have to either reschedule your appointment or be self-pay.

On occasion, emergencies do arise for our physicians. If this should occur, we will notify you as soon as possible to reschedule your appointment. We appreciate your consideration in the matter.

NO SHOW AND CANCELLATION POLICY

Patients who do not keep their office visit or procedure appointments or provide a 24-hour notice of cancellation will be subject to a charge of $50.00 for office visit and $100.00 charge for a procedure.

PHARMACY INFORMATION

We require your pharmacy's phone number and address. If you do not know the information, please call to get the information. We will not be able to obtain it for you.

Patient Name: ____

Pharmacy Name: ______________________________________ Pharmacy Number: ______________________________

Pharmacy Address: ____

REGIONAL PAIN CARE CENTER

Your physician may refer you to Pain Car of North Texas for treatment. Ambulatory surgery has been chosen as the most effective method for treatment.

This is to notify you that Dr. Deborah Holubec, Dr. Jerry Holubec and Dr. Wesley Merritt have financial interest in this facility.

Patient's Signature: ____ Date: ___________________________

Authorized Rep. Signature: ____ Date: __________________________

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
4th Edition: Developed by the Texas Pain Society, August 2017 (www.texaspain.org)

NAME OF PATIENT: ____________________________________ DATE: ________________________

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I have discussed the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief and improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

<u>I HAVE BEEN INFORMED AND</u> understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from your care.

<u>For female patients only (*Indicate by Initialing*):</u>
______To the best of my knowledge **I am NOT pregnant.**
______If I am not pregnant, I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.
______**If I become pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

<u>I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:</u> constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

The term "pain management physician" below means your primary pain management physician or another physician covering for the primary pain management physician.

My pain management physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

(*Patient Shall Indicate All Provisions by Initialing*)

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my pain management physician each time a prescription is written.

_____I agree to submit to laboratory tests for drug levels upon request, including urine and/or blood screens, to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. My pain management physician may limit the number and frequency of prescription refills.

_____ I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**

_____ My pain management physician will manage all of my acute and chronic pain symptoms**. Only my pain management physician may prescribe dangerous and scheduled drugs for the treatment of chronic pain**. I will receive controlled substance medication(s) **only from ONE pain management physician,** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my pain management physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my pain management physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician.

_____I agree that I **shall inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

_____I hereby give my pain management physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain management physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____ I will use the medication(s) **exactly as directed by my pain management physician**. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

_____ If anyone other than my pain management physician prescribes me medication(s) to treat acute or chronic pain, then I will **disclose** this information to my pain management physician at or before my next date of service, which must include at a minimum the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

_____ All medication(s) must be obtained at **one pharmacy designated by me**, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed

medications at my designated pharmacy. Should the need arise to change pharmacies, my pain management physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my pain management physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued**.

_____ I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

_____ I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.

_____ I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.

_____If it appears to my pain management physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my pain management physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my pain management physician liable for problems caused by the discontinuance of medication(s).

_____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my pain management physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

I certify and agree to the following (*Patient Shall Indicate All Provisions by Initialing*):

_____ 1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

_____ 2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

_____ 3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____ 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

____
Name and contact information for pharmacy

_____________________________   _____________________________
Patient Signature   Physician Signature *(or Appropriately Authorized Assistant)*

_____________________________   _____________________________
Patient name printed   Physician name printed *(or Appropriately Authorized Assistant)*

____
Date of birth