

PERRY R. SECOR M.D. F.A.A.O.S.
CHRISTOPHER J. WOODSON M.D.

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New Patient Forms (Check List)

Please make sure you have completed ALL of the following forms and remember to bring them to your first appointment.

- 1. Patient Registration
- 2. Orthopaedic History (2 pages)
- 3. Health History (2 pages)
- 4. Osteoporosis Questionnaire
- 5. Patient Pain (2 pages)
- 6. Privacy Notice Acknowledgement (3 pages)
- 7. Permission for Phone Messages
- 8. Financial Policy
- 9. Office Policy
- 10. Medical Records
- 11. Pain Medication Agreement

Patient Name: _____
Last First Middle Initial Nickname

Home Address: _____
Street Apt#

_____ City State Zip

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact: _____ Emergency Phone: _____

Gender: Male Female Body part evaluated: _____

Marital Status: Single Married Separated Divorced Widow/er

Birthdate: _____ Age: _____ Social Security#: _____

Primary Care Physician: _____

Referred by (doctor/patient/friend): _____

Patient's Employer/School: _____

BILLING INFORMATION:

Primary Insurance:	Secondary Insurance:
Ins. Co. Name: _____	Ins. Co. Name: _____
Subscriber Name: _____	Subscriber Name: _____
Date of Birth: _____	Date of Birth: _____
Policy #: _____	Policy #: _____
Group#: _____	Group#: _____
Employer: _____	Employer: _____
Does your insurance carrier require a referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a labor or industrial claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE PAYMENT AUTHORIZATION:

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me by any of the physicians at Los Alamitos Orthopaedic Medical and Surgical Group. I authorize any holder of medical information about me to release to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

Signature _____ Date _____

Please take a few minutes to complete this form. By doing so you will help your physician to provide the best medical care possible.

Thank you.

NAME:	AGE:	DATE:
Location of problem?		Onset Date:
If injury, describe briefly:		
Any previous surgery at problem site?		Date:
Have you been hospitalized for your pain problem?		
Have you been hospitalized for other medical problems?		

WHAT ARE YOUR MAIN COMPLAINTS?

Head Pain Neck Spasms Stiffness

DOES PAIN RADIATE TO YOUR UPPER EXTREMITIES?

Yes No

Shoulders Traps Right Left Both

Elbows: Right Left Both

Wrists: Right Left Both

Fingers (which)? _____

DOES PAIN RADIATE TO YOUR LOWER EXTREMITIES?

Yes No

Hips: Right Left Both

Knees: Right Left Both

Ankles: Right Left Both

Feet: Right Left Both

SYMPTOMS/COMPLAINTS:

Stiffness: none occasional frequent

Numbness/tingling Yes No Where

Swelling none occasional frequent constant

Weakness Yes No Where

Limited/painful motion Yes No

Grinding/Grating none occasional frequent

Night Pain Yes No

Giving Way/Buckling none occasional frequent

Locking: none occasional frequent

Bowel/Bladder Incontinence Yes No

When (roughly what date) did your present pain start? _____

How long have you had this pain? Years Months Weeks

HOW DID YOUR PAIN START?

- Suddenly Gradually Lifting Twisting Fall Bending Pulling Injured at work Injured in auto accident
 Hit from behind Injured during sports No apparent cause

Did you feel/hear a pop or tear? Yes No Unsure

Did your joint pop out? Yes No Unsure

Did you have weakness? Yes No Unsure

Did you continue activity? Yes No Unsure

Did it feel loose/unstable? Yes No Unsure

WHAT ACTIVITY MAKES THE PAIN WORSE?

- Exercise (during) Exercise (after) Sitting Standing Walking
 Bending Forward Bending backwards Coughing Sneezing

WHAT REDUCES THE PAIN?

- Lying down Sitting Standing Walking Manipulation
 Exercises in physical therapy Pain pills Injections for pain
 Muscle relaxant pills Anti-inflammatory pills Nothing Other

PRIOR TREATMENT:

Did you see a physician? Yes No Dr. Name: _____

Have you had any of these diagnostic studies?

- X-rays: Yes No Date: _____
 CT Scan: Yes No Date: _____
 Myelogram: Yes No Date: _____
 EMG / Nerve Conduction: Yes No Date: _____
 Discogram: Yes No Date: _____
 MRI: Yes No Date: _____
 Arthrogram or sonogram: Yes No Date: _____
 Injections: Yes No Date: _____
 Medication prescribed? Yes No Rx Name: _____
 Physical Therapy? Yes No
 Other treatment? _____

PRESENT OVERALL FUNCTION:

How far can you walk? Blocks _____ Miles _____

Can you climb stairs? Yes No without assistance with assistance

What is your present occupation? _____

Are you currently working? Yes No (if No) date last worked _____

DATE: _____

NAME: _____ DATE OF BIRTH: _____

MEDICATIONS: (Please list medications, dose, and frequency)

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

DRUG ALLERGIES: _____ None Known

HISTORY OF ANY SURGERY: _____

SOCIAL HISTORY:

Do you live: Alone w/Spouse w/Family Apt/Condo House Assisted Living

Caffeine: No Yes How Much: _____

Smoke: No Yes How Much: _____

Alcohol: No Yes Type/Frequency: _____

Are you employed? No Yes

What is your job? _____ Are you exposed to fumes, dusts or solvents? Yes No

Education: (years) High School College Postgraduate

Have you had any serious illness: Yes No

Have you ever been hospitalized or been under medical care for very long? Yes No

If yes, for what reason? _____

OPERATIONS:

Have you had any surgery? Yes No

If yes, please describe: _____

INJURIES:

Have you had any broken bones? Yes No

Have you had any head concussions or injuries? Yes No

Have you ever been knocked unconscious? Yes No

Has any blood relative ever had:

FAMILY HISTORY:	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Suicide
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Bleeding Tendency
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Gout or other Arthritis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hereditary Defects

Have you ever had:

YOUR HISTORY:	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Tendency
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Gout or other Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hereditary Defects
<input type="checkbox"/> Stroke	

SYSTEMIC REVIEW:	YES	NO
General:		
Recent weight change		
Have you been in good health most of your life		
Skin:		
Skin disease		
Jaundice		
Hives, eczema or rash		
Frequent infection or boils		
Abnormal pigmentation		
Head-Eyes-Ears-Nose-Throat:		
Eye diseases or injury		
Do you wear glasses		
Double vision		
Headaches		
Glaucoma		
Sneezing or running nose		
Nosebleeds		
Chronic sinus trouble		
Ear disease		
Impaired hearing		
Dizziness or transient episodes or unconsciousness		
Neck:		
Stiffness		
Thyroid trouble		
Enlarged glands		
Respiratory:		
URI (cold) now		
Spitting up blood		
Asthma or wheezing		
Difficulty breathing		
Any trouble with lungs		
Pleurisy or pneumonia		
Cardiovascular:		
Chest pain or angina pectoris		
Shortness or breath with walking or laying down		
Difficulty walking two blocks		
Heart trouble or heart attacks		
High blood pressure		
Swelling of hands, feet or ankles		
Awakening in the night smothering		
Heart murmur		
Gastrointestinal:		
Peptic ulcer (stomach or duodenal)		
Vomiting blood or food		
Gallbladder disease		
Liver trouble		
Bleeding with bowel movements		

SYSTEMIC REVIEW:	YES	NO
Gastrointestinal: (con't)		
Hepatitis		
Painful bowel movements		
Black Stools		
Hemorrhoids or piles		
Recent change in bowel habits		
Frequent diarrhea		
Heartburn or indigestion		
Cramping or pain in the abdomen		
Does food stick in throat		
Genitourinary:		
Loss of urine		
Frequent urination		
Night time urinating		
Burning or painful urination		
Blood in urine		
Kidney trouble		
Kidney stones		
Bright's disease		
Locomotor – musculoskeletal:		
Varicose veins		
Weakness of muscles or joints		
Any difficulty in waking		
Any pain in calves or buttocks while walking (relieved by rest)		
Neuro – Psychiatric:		
Have you ever had psychiatric care		
Have you been advised to see a psychiatrist		
Do you ever have or have had fainting spells		
Convulsions		
Paralysis		
Hematologic:		
Are you slow to heal after cuts		
Anemia		
Phlebitis		
Have you had difficulty with bleeding excessively after tooth extraction or surgery		
Have you had abnormal bruising or bleeding		
Blood disease		
Allergic:		
Any allergies, including medication		
Endocrine:		
Thyroid disease		
Hormone therapy		
Any change in hat or glove size		
Any change in hair growth		
Have you become colder or skin become dryer		

DATE: _____

NAME: _____ DATE OF BIRTH: _____

DATE OF LAST DEXASCAN: _____

LOCATION TAKEN: _____ DOCTOR: _____

RISK FACTOR INFORMATION:

Height: _____ Weight: _____

Race: Caucasian Asian Hispanic African American

Menstrual Status: Regular Irregular Menopause/When? Yes No

History of fractures in relatives over 65 yrs? Yes No

If yes, state relation and which bones:

Have you had any recent falls? Yes No

When?

Steroids use? Yes No

Impaired vision? Yes No

Liver problems? Yes No

Current smoker? Yes No

How many years?

How many packs per day?

Low calcium intake? Yes No

Lactose intolerant? Yes No

Physically active? Yes No

Alcohol intake? Yes No

More than 2 drinks per day?

Hyperthyroidism or Thyroid Replacement Therapy? Yes No

Kidney problems? Yes No

Have you ever been diagnosed with Osteoporosis? Yes No

Male sexual problems? Yes No

Prolonged immobilizations? Yes No

Stomach problems? Yes No

Heartburn? Yes No

Medication?

Irritable bowel? Yes No

Gastric bypass? Yes No

Patient Name (*Hombre*):

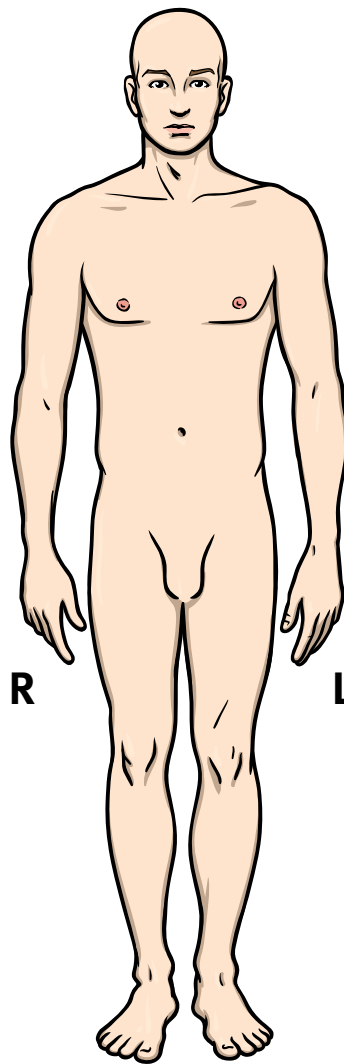
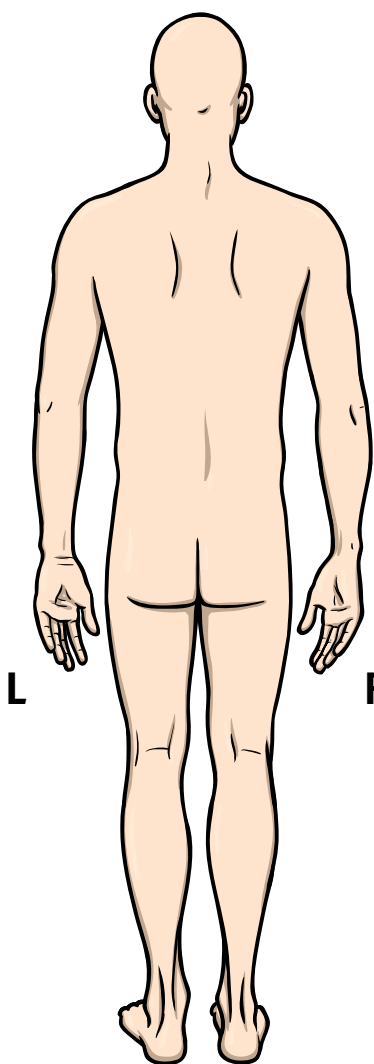
Date (*Fecha*):

Mark the area on your body where you feel the described sensations.

Numbness	Tingling	Burning	Stabbing	Aching	Cramping	Sensitive	Other
0000	tttt	xxxx	////	====	cccc	ssss	pppp

Marke el area en su cuerpo donde usted siente las sensaciones descritas.

Adormecido	Hormiguero	Quemando	Cuchillada	Adolorido	Calambre	Sencible	Otro
0000	tttt	xxxx	////	====	cccc	ssss	pppp



Signature (*Firma*):

Date (*Fecha*):

PAIN RATING SCALES (*Escalas para medir dolor*)**Patient name** (*Hombre*):**Date** (*Fecha*):

Here is a thermometer with *various* grades of pain from *"no pain at all"* at the bottom to the *"pain is almost unbearable"* at the top. We want you to put a check by the phrase that describes your pain best. Please rate your pain over the last month.

(Favor de indicar cuanto fue su dolor la semana pasada)

- Pain is almost unbearable (*Dolores intolerable*)
- Very bad pain (*Dolor muy fuerte*)
- Quite bad pain (*Dolor fuerte*)
- Moderate pain (*Dolor en cantidad moderada*)
- Little pain (*Muy poco dolor*)
- No pain at all (*Sin dolor alguno*)

Please rate your highest level of pain last week. (Favor de indicar manta fue su dolor la semana pasada)

1	2	3	4	5	6	7	8	9	10
No pain (<i>No dolor</i>)					Worst possible pain (<i>El peor posible</i>)				

Signature (*Firma*):**Date** (*Fecha*):

HIPAA Notice of Privacy Practices

LOS ALAMITOS ORTHOPAEDIC SURGICAL AND MEDICAL GROUP

3771 KATELLA AVE. SUITE 209

(562) 314-1400

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

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

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

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

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

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

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) — Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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

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

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

You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Carol Olivarez, Privacy Officer
Los Alamitos Orthopaedic Medical and Surgical Group
3771 Katella Avenue, Suite 209
Los Alamitos, California 90720

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Carol Olivarez, Privacy Officer
Los Alamitos Orthopaedic Medical and Surgical Group
3771 Katella Avenue, Suite 209
Los Alamitos, California 90720

Our **Notice of Privacy Practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship
(parent, legal guardian, personal representative)

This form will be retained in your medical record

PERMISSION TO LEAVE PHONE MESSAGES

Dear Patient:

HIPPA privacy guidelines prevent us from leaving messages for you regarding appointments or any other medical matter.

In order to efficiently communicate with you regarding appointment confirmations, changes or availability please sign below, thereby giving us permission to leave a message on your answering machine, service or with a family member.

This waiver will apply only to messages regarding your appointment(s) or the need for the Doctors or their staff to speak with you regarding procedures or results. No other medical information will be communicated.

I give permission for the Doctor's or their staff to leave phone messages with:

Family members: YES NO

Answering machine/service: YES NO

Patient's Name (PRINT)

Patient's Signature

Date

It is important to clarify our financial policy with each patient. This prevents misunderstanding and unnecessary hard feelings.

We make every effort to keep the cost of medical care down.

If you have insurance, as a courtesy we will bill the insurance company for you. Please understand that insurance policies represent an agreement between you and your insurance company. You are responsible for the payment of your bill regardless of the status of your claim.

All patient co-payments and coinsurance are to be paid in full at the time services are rendered. Cash, check, Visa and Mastercard are accepted. Telephone verification of your insurance coverage does not guarantee the claim will be paid. If you are dissatisfied with your insurance company's processing or payment of your claim, it will be your responsibility to arbitrate this matter with them. We will be glad to supply you with a copy of the claim for arbitration.

Surgical Fees

The insurance company will be billed following surgery; however the patient responsibility portion will be due and payable at your first post-operative office visit. At your request, an estimate of those fees will be made for you prior to your surgery. This will only be an estimate based on the expected procedures and services performed. If the insurance company does not pay for the service provided it is the patient's responsibility to pay the balance within 30 days from the date of surgery.

Insurance Contracts and our office

Contracts between the insurance companies and our office change continually. You may call our office to see if your insurance is currently accepted. We are **NOT** contracted with Medi-Cal. You will be notified by mail if we no longer accept your insurance. You have the option at that time to continue treatment with our physicians by accepting all financial responsibility for your medical treatment or you may have your care and medical records transferred to another physician of your choice.

Returned Check Policy

A \$25.00 fee will be charges for all returned checks.

Payment by cashier's check or money order will be required to replace the dishonored check.

I have read the above financial policy and understand and accept my responsibilities as a patient.

Signed

Date

Witnessed

Date

APPOINTMENT POLICY

In order to provide our patients with timely scheduling options, the following office policies are now in place at our office.

Please become familiar with them.

Changes to Appointments:

We require a minimum of 24 hours notice to change the time or date of your appointment. Please contact the scheduling desk to request a change.

If you are delayed and cannot be on time for your appointment kindly call the office. Please be aware that it may not be possible to see your Doctor that same day however, we will make every effort to do so.

Cancellations and No Shows:

Patients will be charged \$25.00 for each "No Show" or cancellation not made at least 24 hours before the scheduled appointment.

FORMS COMPLETION

There is a \$25.00 form fee that applies to all forms being requested for completion (other than EDD and FLMA).

Fees are due at the time the forms are brought to the office. Forms will not be completed before fee is paid.

Please allow 10 business days for processing of all forms.

AUTHORIZATION TO RELEASE OR RECEIVE CONFIDENTIAL MEDICAL RECORDS

Patient Name

Date of Birth

Doctor requesting/sending records

Doctor or hospital to relinquish or receive records

Address: **Los Alamitos Orthopaedic Medical and Surgical Group**
3771 Katella Ave. Suite 209
Los Alamitos, CA 90720

Telephone: **562-314-1400**

Fax: **562-431-0564**

This authorization to receive/release confidential medical records is to comply with the terms of the appropriate governing codes, including California civil section 56 et.seq., California evidence code section 115B and other.

The undersigned, hereby authorizes the party listed above to furnish or receive from the above the following requested medical information:

 X-Ray Reports All Medical Records Other: _____ X-Ray Films Laboratory Reports

This authorization shall become effective immediately and shall remain in effect as long and as necessary the person requesting/receiving to fulfill obligations requested.

Photocopy of this authorization shall be considered as valid as the original.

Patient Name

Date

Signature

PAIN MEDICATION AGREEMENT

I understand that Dr. Secor/Dr. Woodson is an orthopaedic surgeon, not a pain management specialist. Dr. Secor/Dr. Woodson's goal is to treat your acute pain as it directly relates to procedures administered by this office. Dr. Secor/Dr. Woodson will do his best to treat your acute pain for a period of 90 days after which you may be referred to a doctor who specializes in pain management. Surgery patients will be reviewed and treated on a case-by-case basis, staying within the limits of the law.

The purpose of this Agreement is to prevent misunderstandings about certain medicines you may be taking for acute pain. This is to help both you and your doctor(s) to comply with the law regarding controlled pharmaceuticals. Doctor(s) and I agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. If I fail to abide by the terms of this agreement, it may result in the withdrawal of all prescribed medication by the Doctor/PA and the termination of the Doctor/Patient relationship.

In this case, Doctor(s) will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also a drug-dependence treatment program may be recommended.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication for money, goods or services.

I will safeguard my medication/prescription from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time. Lost or stolen medicines/prescriptions will not be replaced.

I agree not to drive or operate heavy equipment while taking pain medication. If I am going to drive, I will agree not to take scheduled medication dose.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor/PA. I understand it is against the law to do so. If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure there is no duplication. I will discontinue all previously used pain medications unless told to continue them.

I authorize the doctor(s) and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor(s) to determine my compliance with my program of acute pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time and could possibly cause my death. I realize that all medications have potential side effects and I will have the laboratory studies required to keep the regimen as safe as possible.

I understand that my doctor will review this medication regimen from time to time.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. I also understand that failure to sign this contract will prevent the doctor/PA from prescribing any medications.

I agree to use _____ Pharmacy,

located at _____

Pharmacy number _____

This agreement is entered into on this _____ day of _____, 20 _____

Patient signature _____

Witnessed by doctor(s) representative _____