CRPM
CENTERS OF REHABILITATION AND PAIN MEDICINE

Albert Lai, MD Shinto Koshy, MD DaSol Hwang, FNP Roxanne Manuel PA-C

OFFICE: 714-223-7000 FAX: 714-223-7001

Welcome! Thank you for choosing our office to assist you with your rehabilitation.

NEW PATIENTS

To provide our patients with the best level of care, it is imperative that we receive a documented medical history to review before you can be seen by one of our Providers.

All current medical documentation should be faxed or mailed to our office at least 48 hours prior to your scheduled consultation.

Please include all :

- ☐ **Medical visit notes**
- ☐ **Imaging (MRI and/or XRAY) with reports**
- ☐ **Physical Therapy notes**
- ☐ **Surgical Reports**
- ☐ **List of current medications**

Please remember that all documents and imaging must be **specific to the body part** with which you are being seen at the time of your consultation.

ALBERT LAI, M.D.
SHINTO KOSHY, M.D.
DASOL (AMY) HWANG, F.N.P.
ROXANNE MANUEL, PA-C

This letter is to confirm your appointment on

_____.

****You must arrive 30 minutes early at the following location or your appointment may be rescheduled:**

☐ 1041 E. YORBA LINDA BLVD.
SUITE 210
PLACENTIA, CA 92870

☐ 1010 W. LA VETA
SUITE 615
ORANGE, CA 92868

For your convenience, our patient packet will be mailed or emailed to you. Please bring this packet with you to your appointment fully completed. <u>If not completed, your appointment may be rescheduled.</u>

Please bring the following items to your appointment:

- ☐ ***Photo ID & Insurance Card***
- ☐ ***All Current prescription medication bottles***
- ☐ ***Copies of radiology reports + films / MRI / X-rays***
- ☐ ***Reminder: We do NOT accept checks for copays.***
  For your convenience, we accept cash, Visa & Mastercard

Should you require additional assistance or have questions regarding this information, please do not hesitate to contact us at **(714) 223-7000** or if you need to FAX us, please Fax: **(714) 223-7001**

Once again, we look forward to meeting you.

OUTSIDE MEDICAL RECORDS PROTOCOL

Thank you for choosing Centers of Rehabilitation and Pain Medicine to assist you with your rehabilitation. We are committed to providing you with the best possible care and treatment.

To be able to provide you with proper treatment we must have medical records outlining your recent medical care to include office visit notes, radiology testing, lab results and medication lists.

We must have copies of your medical records in our office prior to your appointment. If you have been referred by another medical office, we will call them to request your medical records be sent to our office prior to your appointment.

If you are obtaining the medical records, they must be provided to our office no later than the ***day before*** your appointment. You may fax them to 714-223-7001. If you choose to fax records, please notify our office at 714-223-7000, so we can let you know if we do not receive them.

If we do not receive medical records prior to your appointment, we will be unable to write any medications for you until we do receive them.

You may call our office at 714-223-7000 the day before your appointment to verify we have received your records.

If you choose not to provide us with records, you must have a medical work up possibly to include: radiology testing, electrical studies and lab work before we will be able to safely write you prescriptions for medications.

Thank you for your understanding and cooperation,

Management

Centers of Rehabilitation & Pain Medicine

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OFFICE: 714-223-7000 FAX: 714-223-7001

AUTHORIZATION TO RELEASE INFORMATION

Patient Name (Last):_____(First):_____

DOB: _____ SS#: _____

Cell # ( ) _____ Day Phone # ( ) _____

INFORMATION REQUESTED ***FROM:***

Name:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ FAX: ( )_____

INFORMATION REQUESTED ***TO:***

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ FAX: ( )_____

Information I would like sent / requested:

_____ Copies of pertinent info only (H&P, OP reports, Labs, Imaging Reports)

_____ Copy of entire medical record

_____ Other (Please Specify)_____

Patient Signature: _____ Date: _____

Please send to ***FAX# 714-223-7001*** or

Mail to: 1041 E. Yorba Linda Blvd. Suite #210, Placentia, CA 92870

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PATIENT REGISTRATION

LAST NAME: _____

FIRST NAME: _____ MIDDLE NAME :_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

SEX: M F DRIVERS LICENSE #:_____ STATE: _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

RACE: _____ ETHNICITY: _____

PARENT/GUARDIAN NAME (if patient is a minor): _____

RELATIONSHIP TO MINOR: _____

HOME STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

*PLEASE INDICATE BELOW WHICH IS YOUR PRIMARY PHONE NUMBER

☐ HOME #:_____ ☐ MOBILE #:_____

May our office leave a message on your primary voicemail? YES NO

EMAIL ADDRESS:_____

EMPLOYER:_____OCCUPATION:_____

WORK ADDRESS:_____

EMERGENCY CONTACT (OTHER THAN YOUR OWN NUMBER)

NAME:_____ PHONE NUMBER:_____

Primary Insurance:

NAME OF PRIMARY INS CO:_____ PHONE:_____

ID/POLICY NUMBER:_____ GROUP NUMBER:_____

SUBSCRIBER/INSURED:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

INSURED EMPLOYER NAME:_____

EMPLOYER PHONE:_____

Secondary Insurance:

NAME OF SECONDARY INS CO:_____ PHONE:_____

ID/POLICY NUMBER:_____ GROUP

NUMBER:_____

SUBSCRIBER/INSURED:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

INSURED EMPLOYER NAME:_____

EMPLOYER PHONE:_____

General Medical Consent: The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to x-ray examinations, laboratory procedures and medical services rendered to patient under the general and special instructions of the physician. It is understood that the patient is under the care and supervision of his/her attending physician.

I, the undersigned, assign directly to the Office of Albert Lai, M.D. all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I will be required to present my health insurance card and driver's license to ensure coverage and identity. I hereby authorize the doctor to release all information necessary to secure payment of benefits. Should my insurance deny payment I am fully aware that I am responsible for all charges incurred.

_____ _____

Signature of Patient, Parent, Legal Guardian or Legal Representative Date

ALBERT LAI, M.D.
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ROXANNE MANUEL, PA-C

Financial Policy

We want to welcome you to our office. We are committed to providing you with the best possible care and we will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions that you may have about our fees, financial policy or your responsibilities.

We cannot bill your insurance unless you bring your complete insurance information with you. Our office will bill your insurance as a courtesy, but ultimately the balance is your responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. **If you have a co-payment with your insurance it is due at the time of service or we will charge you a $15 billing fee per missed co-payment.** You may choose to pay by cash, Visa or Mastercard. It is necessary for you to verify your benefits through your insurance, as some services may be considered "non-covered" or may have a benefit limitation.

Auto Accidents— We will bill your auto insurance if you have "Med Pay" on your policy. **If you are represented and you lose your case you are fully responsible for all charges.**

Medicare Clients— Medicare will pay 80% of the acceptable charges. If you have a secondary insurance, we will bill them for the remaining 20%. If you do not have a secondary insurance, the balance will be due and payable by you. You will receive a statement for your portion after Medicare has completed their payments.

I have fully read the above and fully understand and agree to the terms of this policy. I hereby assign all medical benefits to the Offices of Albert Lai, M.D. I understand I am personally responsible for all legitimate charges incurred, regardless of insurance coverage.

_____ _____

Responsible Party Signature Date

ALBERT LAI, M.D.
SHINTO KOSHY, M.D.
DASOL (AMY) HWANG, F.N.P.
ROXANNE MANUEL, PA-C

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION - (HIPAA)

I, _____ understand the Offices of Albert Lai, M.D., is not authorized by me to use or disclose my protected health information for purpose other than treatment, or health care operations.

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of the Offices of Albert Lai, M.D., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply)

☐ The patient's entire medical record (NOTE: This requires an explanation as to why the entire record may be disclosed) The patient's demographic information (check all that apply)

☐ Name	☐ Street/Zip Code Only	☐ Specific condition(s)
☐ Address	☐ Telephone	☐ Specific medication(s)
☐ Age	☐ Gender	☐ Specific professional service(s)
☐ Race		

☐ Other _____
_____
_____

Name of person(s) other than myself authorized by this form to use and disclose the protected health information (family members, etc)_____
_____
_____

I authorize the Offices of Albert Lai, M.D. to contact me by mail or phone regarding information or services that may be helpful or beneficial to me.

Signature:_____ Date: _____

CRPM

Patient Reschedule - Cancellation and Late Policy

Cancelling or Rescheduling	NEW Patients	ESTABLISHED Patients	LATE = Rescheduled
			
24 HRS NOTICE	**30 MIN BEFORE**	**15 MIN BEFORE**	**10 MIN IS LATE**
Should you need to reschedule or cancel.	Please arrive 30 minutes prior to your appointment.	Please arrive 15 minutes prior to your appointment.	Patients arriving 10 minutes or later will be rescheduled.

A "no-show" policy which will affect all who do not keep their appointment or cancel with less than a 24-hour notice.

Patients arriving 15 minutes or more after will be considered as a "no-show" and will be rescheduled, in addition:

1st occurrence – Patient/parent will receive a letter advising of our policy.
2nd occurrence – 2nd letter + a **$50 No Show Fee** assessment.
3rd and subsequent occurrences – May potentially result in dismissal from practice + **an additional $50 No Show Fee**

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Patient Reschedule / Late Arrivals / Cancellation Policy

In order for us to continue to provide the highest quality service and to minimize your wait time, it is requested that you give **24** hour notice, should you need to reschedule or cancel an appointment.

NEW Patients, please arrive to your appointment **30** minutes prior to your scheduled appointment.
ESTABLISHED Patients, please arrive to your appointment **15** minutes prior to your scheduled appointment.

Patients arriving **10** minutes or later for a scheduled appointment will be rescheduled.

A "no-show" policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

Patients arriving **15** minutes or more after their scheduled appointment will be considered as a "no-show" and will be rescheduled at another time, in addition:

- First occurrence – Patient/parent will receive a letter advising of our policy.
- Second occurrence – Patient/parent will receive a 2nd letter and a **$50** no show fee assessment
- Third and subsequent occurrences – May potentially result in dismissal from practice and an additional **$50** no show fee

I understand that I may be charged a $50.00 fee for each cancelled/no show appointment where a 24 hour notice has not been provided.

Patient Signature:_____

Patient Name (Please Print):_____

Date:_____

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Call Monitoring and Recording Acknowledgment

This acknowledges that you understand and agree that Centers of Rehabilitation and Pain Medicine's (CRPM) phone calls and its recordings may be used for the purposes of customer service, examination, and/or training purposes. Call data and recordings are protected by systems that are HIPAA compliant.

I hereby acknowledge and understand that Centers of Rehabilitation and Pain Medicine (CRPM) records and review calls for training, examination, and/or quality assurance purposes.

Signature: _____ Date: _____

Name (Print):_____

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New Patient Questionnaire

Name:_____

Age: _____ Sex: _____ Height:_____ Weight: _____

Current Problem:_____

Any imaging studies for this problem? ☐ **Yes** ☐ **No**

Who referred you? _____

Who is your primary provider / doctor?

_____

History of Present Illness (history of painful situation / description of pain)

_____

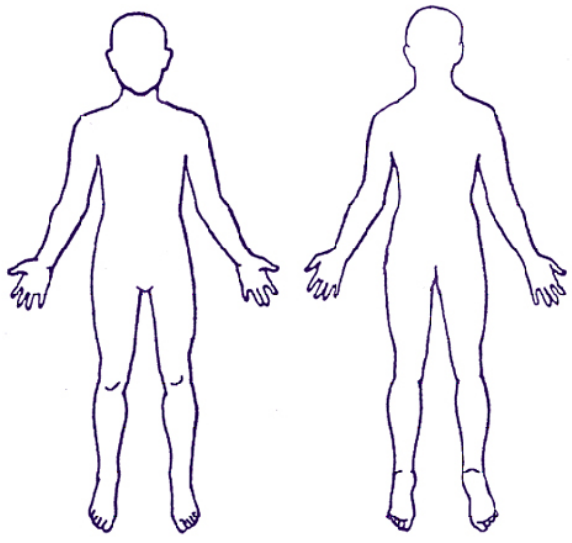
_____

_____

_____

WHERE IS THE PAIN? Please mark on the drawing where you feel pain right now.

Front _____ **Back**



Please Use the Key Below

Pins & Needles = o o o
Stabbing = / / /
Burning = X X X
Deep Aches = Z Z Z

Rate Your Pain:

0 = No Pain 10 = Worst Pain Ever

1. Right now: 1 2 3 4 5 6 7 8 9 10
2. At Best: 1 2 3 4 5 6 7 8 9 10
3. At Worst: 1 2 3 4 5 6 7 8 9 10

Describe Your Pain: **Dull Sharp Aching Stabbing Burning Shooting Tingling Numbness**

How does the pain change with: Worse (W) Better (B) No Change (O)

Sitting:_____ Standing:_____ Bending Backwards:_____ Bending Forwards:_____

Laying Down:_____ Walking:_____ Twisting:_____ Sneezing:_____ PT:_____ Massage:_____

Medications:_____Other:_____

How long can you: Sit _____ minutes Stand_____minutes

Allergies / Sensitivities:

Please list any reaction you may have or had to any medications:

Medication:	Reaction:
_____	_____
_____	_____
_____	_____

Medication:

Please list all medications you are currently taking:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently seeing any other medical doctors for your painful condition?

Please list their names and phone numbers:

Name:	Phone:
_____	_____
_____	_____

Please write down any X-rays, MRIs, CAT Scans, EMG (Nerve tests) and any other tests you have had: (please enclose copies of the results, including films if you have them, if not please list body part, facility, and telephone number)

Facility:	Phone:	Image:
_____	_____	_____
_____	_____	_____
_____	_____	_____

What Medical Treatment Have You Had?:

	Dates:	Did this help your pain?
☐ **Physical Therapy**	_____	☐ **YES** ☐ **NO** **If YES, How many times?** _____
☐ **Psychologist**	_____	☐ **YES** ☐ **NO** **If YES, Name:** _____
☐ **Spine Injection**	_____	☐ **YES** ☐ **NO** **If YES, Procedure:**_____
☐ **Trigger Point Injections**	_____	☐ **YES** ☐ **NO**
☐ **T.E.N.S. (Nerve Stimulator)**	_____	☐ **YES** ☐ **NO**
☐ **Heat/ Ice Treatment**	_____	☐ **YES** ☐ **NO**
☐ **Acupuncture**	_____	☐ **YES** ☐ **NO**
☐ **Chiropractic Therapy**	_____	☐ **YES** ☐ **NO**
☐ **Other**	_____	☐ **YES** ☐ **NO** **If YES, Procedure:**_____

Does the pain limit your activities of daily living? ☐ YES ☐ NO

If yes, what percent of the day? ☐ **10%** ☐ **25%** ☐ **50%** ☐ **75%** ☐ **100%**

Self Care: ☐ **Showering** ☐ **Hair Brushing** ☐ **Teeth Brushing** ☐ **Putting on clothes**

Communication: ☐ **Speaking** ☐ **Writing** ☐ **Typing**

Physical Activity: ☐ **Walking Stairs** ☐ **Walking** ☐ **Standing** ☐ **Sitting**

Sensory Function: ☐ **Hearing** ☐ **Seeing** ☐ **Feeling** ☐ **Tasting** ☐ **Smelling**

Hand Activity: ☐ **Lifting** ☐ **Grasping** ☐ **Turning Pages** ☐ **Feeling Things**

Travel: ☐ **Driving a Car** ☐ **Turning head to look in mirror** ☐ **Pain with sitting** ☐ **Pain w/ bumps in road**

Sexual Function: ☐ **Performing** ☐ **Erection** ☐ **Ejaculation** ☐ **Enjoying**

Past Medical History: (Check Box) Specify If Known

☐ **Heart Disease/Attack** ☐ **Diabetes** ☐ **Lung Problems:**_____

☐ **High Blood Pressure** ☐ **Seizures** ☐ **Cancer:**_____

☐ **TIA/Stroke** ☐ **Thyroid:**_____ ☐ **HIV:**_____

☐ **Bleeding Problems** ☐ **Hepatitis:**_____ ☐ **Kidney Stones**

☐ **Stomach/Intestine:**_____

☐ **Other:**_____ ☐ **Other:**_____

☐ **Other:** _____ ☐ **Other:**_____

Surgical History:

☐ **Appendectomy** ☐ **Tonsillectomy**

☐ **C-Section** ☐ **Spine Surgery:**_____

☐ **Hysterectomy** ☐ **Joint Replacement:**_____

☐ **Hernia Repair** ☐ **Arthroscopy:**_____

☐ **Carpal Tunnel Surgery** ☐ **Surgery Fracture Repair:**_____

☐ **Gallbladder** ☐ **Other:**_____

☐ **CABG** ☐ **Other:**_____

☐ **CA/Stent** ☐ **Other:**_____

Family History:

Any family medical problems? ☐ **YES** ☐ **NO** **If YES, Please explain?**_____

_____

_____

_____

_____

Social History:

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** Children? ☐ **YES #:_____** ☐ **NO**

Do you drink alcohol (beer, wine, etc)? ☐ **NO** ☐ **YES** ☐ **Daily** ☐ **Weekly** ☐ **Monthly**

Do you smoke cigarettes? ☐ **YES** ☐ **NO** How many packs/day?_____

Do you or have you ever used recreational drugs? ☐ **YES** ☐ **NO**

If Yes, What kind and how often?

_____

Review of Systems - Any problems with: (Check Box)

☐ **Chills**	☐ **Palpitations**	☐ **Back Pain**	☐ **Headaches**
☐ **Sweats**	☐ **Cough**	☐ **Joint Stiffness**	☐ **Numbness/Tingling**
☐ **Fevers**	☐ **Shortness of Breath**	☐ **Joint Swelling**	☐ **Limb Weakness**
☐ **Weight Loss**	☐ **Abdominal Pain**	☐ **Leg Swelling**	☐ **Easy Bruising/Bleeding**
☐ **Weight Gain**	☐ **Constipation**	☐ **Exposure to TB**	☐ **Vision Changes**
☐ **Depression**	☐ **Diarrhea**	☐ **Rash/Lesions**	☐ **Hearing Problems**
☐ **Stress**	☐ **Itching**	☐ **Anxiety**	☐ **Incontinence Urine/Stool**
☐ **Chest Pain**	☐ **Blood in Stool**	☐ **Dizziness**	☐ **Sleep**

Current Work Status:

Job Title/Description:

_____

☐ **Full Time** ☐ **Part Time** ☐ **Student** ☐ **Homemaker** ☐ **Retired** ☐ **Other_____**

☐ **Unemployed, Disabled** ☐ **Unemployed, Not Disabled**

☐ **Length of time unemployed:_____years _____months**

☐ **Working with restrictions: Occupation: _____ Restrictions: _____**

Are you unemployed/underemployed because of your injury? ☐ **YES** ☐ **NO**

<u>Past Injuries or Accidents</u>:

Accident:

Date: _____ Body Part Injured: _____

What happened? _____

Did you get medical treatment? ☐ **YES** ☐ **NO** Did you make a full recovery? ☐ **YES** ☐ **NO**

Has the injury affected your ability to work/ Do you have current restrictions?

_____

<u>Work Related Injury</u>:

Date: _____ Body Part Injured: _____

Have you ever hurt this part before? ☐ **YES** ☐ **NO** How?: _____

_____

Did you get medical treatment? ☐ **YES** ☐ **NO** Who first treated you?:

_____

Where?: _____ Who has treated you since?: _____

Did you make a full recovery? ☐ **YES** ☐ **NO**

Has the injury affected your ability to work / Do you have current restrictions? _____

Date you last worked: _____ Date you started with your employer: _____

What were your job duties and hours? _____

_____

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LONG-TERM CONTROLLED SUBSTANCES THERAPY FOR CHRONIC 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 are controversial because of uncertainty regarding the extent to which they provide long-term benefit. 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 for 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 confirmed prescription of controlled substances to treat your chronic pain.

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 time 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 him or herself

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking pain medicines can cause symptoms like bad flu, called a withdrawal symptom. I agree not to take any of these medicines and to tell any doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history, as well as that of my family, to the best of my knowledge.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specified authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.) Obtaining medications from other healthcare providers without the knowledge of our physicians at CRPM can lead to a discharge and an inability to obtain narcotic prescriptions.
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:
   location and 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 dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability
5. You may not share, trade, sell, or otherwise permit others to have access to these medications.
6. **I agree to take the medications as prescribed.** If I do take more than directed and will run out early, I will notify my physician and I may be asked to come for a discussion. I will not call ‘at the last minute’ and request medications when you’re about to run out early when you have failed to notify the doctor and the CRPM in a timely manner.
7. These drugs should not be stopped abruptly, as a withdrawal syndrome will develop.

8. **Unannounced urine toxicology screens will be requested within 48 hours after you get notified, and your cooperation is required.** Presence of unauthorized substances (unauthorized narcotics, alcohol) may prompt referral for assessment for addictive disorder and result in the discontinuation of medications prescribed by our office..
9. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded.
10. Original Containers of medications should be brought in to the office when requested
11. Since the drug 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.
12. **Medications will not be replaced if they are lost, get wet, are destroyed, misplaced (i.e. left on an airplane), etc... If your medication has been stolen and you complete a police report regarding the theft, an exception may be made after we discuss the situation with you and/or the police.**
13. **Early refills will not be given unless the physician authorizes this on a case by case basis, there is a change in condition, or the exception as described above.**
14. Prescriptions may be issued early if the physician will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they may not be filled prior to the appropriate date. In some cases, extra medication may be given for the sole purpose of giving you enough to last until you return. However, this does not mean that you can take extra during the course of your monthly regimen.
15. I do not use or distribute any illegal or illicit drugs, medications or substances.
16. I agree that discussion about my treatment or changes in my pain medication regimen will take place only during my appointments, and not on the phone, email, or by letter
17. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
18. **It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician or referral for further specialty assessment.**
19. Renewals **are contingent on keeping scheduled appointments. Refills will not be made after two consecutive missed appointments. To keep receiving refills, a pain medicine evaluation is required at least every month**. Please do not phone for refills after hours or on weekends. Refills will be made during scheduled office visits only if the visit coincides with the refill date, by patient pick up at the office, or via pharmacy faxed requests; all types of requests need to be called in **three business days prior to requiring a refill**

20. It should be understood that any medical treatment is initially a trial, and that getting continued prescriptions is contingent on evidence of pain reduction and functional benefit.

21. (Males Only) I am aware that 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. My doctor may reduce or discontinue opioids if these side effects occur.
22. (Females 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 delivery 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 birth defects while I am taking an opioid
23. **I agree that this agreement is essential to my medical care, and my physicians' ability to treat my pain effectively, and that failure on the part of the Patient (myself) to comply with the terms of this agreement may result in the withdrawal of all prescribed medication by the physician/provider at CRPM, and the termination of the physician-patient relationship, with immediate discharge from the physician practice and CRPM.**
24. **I understand that if I am discharged from CRPM and the care of the prescribing physician/provider due to non-compliance with this agreement, that I MAY be given a prescription for a 30 day tapering supply of my medication(s), so as to attempt to avoid withdrawal symptoms.**
25. This agreement will be reviewed and renewed while it is in effect.
26. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accepted all of its terms.

_____ _____

Physician Signature Patient Signature

_____	_____
Date	Patient Printed Name