PAIN & REHABILITATION MEDICINE, LLC

# MEDICAL CLINIC AGREEMENT

1. The medical clinic will provide treatment and medication for chronic pain. I should consult my primary care doctor for all other medical issues.
2. I will take my medications exactly as they are prescribed by the doctor, any adjustments must be approved by the doctor. I understand that the doctor will **not** provide additional medication if I run out ahead of schedule.
3. I will avoid alcohol and illegal substances.
4. If I feel tired or mentally foggy, I will not drive, operate heavy equipment, or serve in any capacity related to public safety.
5. I will submit a drug screen upon my doctor's request. My doctor might ask that a center staff member observe me providing the appropriate specimen.
6. I will sign a release as needed to allow my doctor to contact family members, friends, people I work with and other physicians I am seeing in an effort to monitor my progress.
7. I understand that the doctor will not be available to prescribe medication during evenings, weekends, and after 12:00 noon on Friday. My doctor's partners may not provide me with refills by phone. It is my responsibility to call my doctor at least (3) business days in advance of running out of medications if my appointment gets changed.
8. I will not receive medication (opiates, sleeping pills, tranquillizers, stimulants, etc.) from anyone besides the pain management physician without authorization. If I have an emergency that may require additional pain medication, I will call my doctor's office first. I will alert the doctor at the emergency room or hospital of this agreement with pain management consultants.
9. I will inform my doctor of any changes in any other medications I am receiving from other physicians.
10. I will allow my doctor to receive information from any pharmacy I have used.
11. I will have all my medications filled at the pharmacy listed below and I will notify my doctor of any pharmacy changes.
12. I understand that my doctor will gradually discontinue my pain medications if (a) I do not follow the above plan, or (b) if my doctor believes that my being on pain medications is not helping or harming me.
13. Pain medication will be continued as long as there is (a) acceptable improvement in pain level, (b) reported increase in activities, (c) no inappropriate drug behavior, (d) no significant side effect.
14. "Flare ups" or exacerbations of pain may occur from time to time and will be managed by therapies such as icing, heat, TENS, or relaxation rather than taking additional pain medications unless otherwise specified.
15. It is determined that the exacerbation of pain is out of control, I will agree to be hospitalized. In this case medications and therapies will provided in a controlled fashion.

Initials: _____

16. For women, I will do everything I can to avoid getting pregnant while taking medications unless otherwise approved by my doctor. To the best of my knowledge, I am not pregnant at this time.

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I have read and understand this agreement with the clinic and have been given a copy of the narcotics information sheet.

Name: _____ DOB: _____ Date: _____

Witness: _____ Date: _____

My family doctor is: _____ Phone number: _____

My medications will be filled at: _____

Pharmacy phone number: _____

Pharmacy Address: _____

Referring Physician: _____

Patients Signature: _____

PAIN & REHABILITATION MEDICINE, LLC

NEW PATIENT REGISTRATION FORM

Name: _____ CHART #: _____

Referring physician: _____ DOB: _____

PATIENT HISTORY QUESTIONNAIRE

1. When did your current pain begin? _____
2. Have you had surgery for this problem? _____
3. Are you currently working? _____

4. How did the current pain start? (check appropriate box)

| | | | |
|---|---|---|---|
| [ ] suddenly | [ ] twisting | [ ] pulling | [ ] injured during sports |
| [ ] gradually | [ ] fall | [ ] injured at work | [ ] injured in an auto accident |
| [ ] lifting | [ ] bending | [ ] hit from behind | [ ] no apparent cause. |

5. What activities make the pain worse? (check appropriate box)

| | | | |
|---|---|---|---|
| [ ] exercise | [ ] reaching up | [ ] sitting | [ ] driving |
| [ ] sneezing | [ ] standing | [ ] walking | [ ] coughing |
| [ ] bending forward | [ ] bending backward | | |

6. Medical History (check appropriate box)

| | | | | |
|---|---|---|---|---|
| [ ] diabetes | [ ] COPD | [ ] gout | [ ] heart | [ ] fibromyalgia |
| [ ] headaches | [ ] cancer | [ ] stroke | [ ] anemia | [ ] bowel or bladder |
| [ ] glaucoma | [ ] ulcers | [ ] asthma | [ ] depression. | [ ] kidney disease |
| [ ] arthritis | [ ] GERD | [ ] seizures | [ ] hypertension | |

7. Do you have allergies? _____
8. Do you drink alcohol, if yes, how much per day? _____
9. Do you smoke, if yes, how many packs per day? _____
10. If you have a prior history of alcohol or smoking, when did you quit?_____
11. Family medical history _____
12. List all medications you are currently taking _____

_____

13. Are you on Coumadin, Aspirin, Plavix, or NSAIDS (circle the medication if appropriate)?
14. Have you had an X-ray, CT scan, or MRI in the past year?

_____

THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

PATIENT'S SIGNATURE _____ DATE_____

# THE CENTRAL ORTHOPEDIC GROUP, LLP

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DATE OF EXAM:_____Account number#_____

PATIENT NAME: _____
Responsible Party/ Policy Holder :_____
Insurance Company name: _____ Member Id#_____

How did the occurance happen?

_____
_____
_____

What part of the body was injured/hurt?

_____
_____

Date of Onset: _____

Address of Onset: _____

Was this related to a Motor Vehicle accident yes / no

Was this a Work related accident yes / no

I affirm that the above statement is true and request the release of any monies from my insurance company to the Central Orthopedic Group, LLC.

I also give permission to the Central Orthopedic Group to release any information necessary to pay this claim to my health insurance company.

PATIENT SIGNATURE:_____ Date: _____

Responsible party Signature:_____Date: _____