APM New Patient Packet

Pain Management

Instructions:

The New Patient packet is long, but the information provided will ensure a smooth new patient visit.

The majority of these forms regard consent and permissions for us to treat you as a patient. Please write clearly in the Demographics section.

Complete these forms as best as you can and bring them on the day of your appointment. If you have any questions, you can call our office or ask us in person prior to your appointment time.

ADVANCED PAIN MANAGEMENT CENTER

DEMOGRAPHICS: (PLEASE PRINT CLEARLY)

NAME:	DOB: / /	AGE:	SS# - -
STREET:	CITY:	STATE:	ZIP:
HOME PHONE: ( )	MOBILE PHONE: ( )		(REQUIRED)
EMAIL: @ .			(REQUIRED)
EMERGENCY CONTACT NAME:	EMERGENCY PHONE: ( )		
GENDER: ☐ Male ☐ Female	MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed		
OCCUPATION: (CURRENT OR PREVIOUS)	EMPLOYER:		

ETHNICITY & RACE (REQUIRED BY THE STATE)

☐ Black or African American	☐ Asian	☐ White	☐ American Indian	Other:
Who Referred You to this Office? ☐ Physician ☐ Internet ☐ Friend/Patient				

PRIMARY CARE PHYSICIAN (PCP)

PHYSICIAN NAME:	PHONE: ( )	FAX: ( )
PHYSICIAN ADDRESS:		NPI:

OTHER PHYSICIAN/SPECIALIST (e.g. Orthopedic Surgeon, Psychiatrist)

PHYSICIAN NAME:	PHONE: ( )	FAX: ( )
PHYSICIAN ADDRESS:		NPI:

INSURANCE: PRIMARY

INSURANCE:	ID:	
GROUP NO:	SUBSCRIBER NAME:	DEDUCTIBLE $
RELATIONSHIP TO SUBSCRIBER:	SUBSCRIBER DOB:	CO-PAY: $

INSURANCE: SECONDARY

INSURANCE:	ID:	
GROUP NO:	SUBSCRIBER NAME:	DEDUCTIBLE $
RELATIONSHIP TO SUBSCRIBER:	SUBSCRIBER DOB:	CO-PAY: $

INSURANCE: WORKERS' COMPENSATION

INSURANCE CO:	CLAIM NO:
ADJUSTER:	ADJUSTER PHONE: ( )
ADJUSTER FAX: ( )	DATE OF INJURY:
ATTORNEY:	ATTORNEY PHONE: ( )

INSURANCE AUTHORIZATION & ASSIGNMENT: *I hereby authorize Advanced Pain Management to furnish information to insurance carriers concerning my health information (illness and treatment) and I hereby assign to the physician(s) all payments for medical service for myself and/or my dependents. I understand I am responsible for any amount not covered by my insurance.* **I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY CLAIM THAT HAS BEEN DENIED BY MY INSURANCE DUE TO LACK OF REFERRAL OR ANY SIGNIFICANT INSURANCE INFORMATION DEEMED NECESSARY TO FILE A CLAIM ON MY BEHALF, IF MY INSURANCE CHANGES IT MY RESPONSIBILITY TO UPDATE IT WITH ADVANCED PAIN MANAGEMENT AS SOON AS POSSIBLE OR I MAY BE RESPONSIBLE FOR PAYMENT DUE TO CLAIMS THAT ARE DENIED DUE TO BEING SENT OVER THE FILING LIMIT. ***IF MY ACCOUNT ENDS UP IN COLLECTIONS OR COURT, I WILL BE RESPONSIBLE FOR ALL COSTS INCURRED DUE TO INCLUDE COURT FILING FEES, INTEREST AND LATE FEES.**

I MUST NOTIFY APM IF THIS IS A WC OR AUTO ACCIDENT CASE. IF DETERMINED AT A LATER DATE THAT THIS IS AN AUTO OR WC CASE, I WILL BE FULLY RESPONSIBLE FOR ALL THE CHARGES INCURRED AND NOT PAID BY ACCIDENT/WC INSURANCE.

SIGNATURE OF PATIENT:_____ DATE:_____

PRINTED NAME OF PATIENT:_____

URINE TOXICOLOGY SCREENING:

Signature of Patient or Authorized Individual: Urine/Blood Drug Testing. I agree to have urine toxicology screen at each office visit my physician deems necessary as part of my treatment program. If my insurance company does not allow payment for this procedure, I am responsible for full payment and I understand payment is due upon receipt of invoice.

SIGNATURE OF PATIENT:_____ DATE:_____

INFORMATION REVIEWED BY:_____

NAME

MEDICAL RECEPTIONIST

ADVANCED PAIN MANAGEMENT CENTER
Pain Questionnaire

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Chief Complaint: _____ How long have you had this pain? _____

How did it start?: _____

Work related injury? ☐ Yes ☐ No If yes: ☐ Case Closed-Evidence ☐Case Active

Describe your pain (Please check the box that best describes your pain)

Is your pain [ ] Constant [ ] Intermittent

Is your pain [ ] Sharp [ ] Dull [ ] Shooting [ ] Tightening [ ] Burning
[ ] Throbbing [ ] Boring [ ] Cramping [ ] Aching [ ] Radiating

Intensity of your pain on a scale of 0-10 with 0 being no pain and 10 being excruciating pain, please circle:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild			Moderate					Severe

What makes your pain worse? _____

What makes your pain better? _____

Any cortisone injection: ☐ Epidural ☐ Facet ☐ Other_____

Have you had any other treatment for pain so far? [ ] Yes [ ] No

(1) [ ] Physical Therapy (2) [ ] Physician Directed Home Exercise (3) [ ] Chiropractic
(4) [ ] Accupuncture (5) [ ] Massage (6) [ ] Other _____

Have you had psychological [ ] evaluation [ ] treatment When? _____Where?_____

Does pain interfere with: [ ] work [ ] household work [ ] socializing [ ] sexual relations [ ] sleep

When you are in pain are your family members [ ] supportive [ ] understanding of your problem

When you are in pain are your friends [ ] supportive [ ] understanding of your problem

Due to pain are you [ ] Irritable [ ] Depressed [ ] Anxious

Do you smoke?	[ ] Yes	[ ] No	How much? _____	How long? _____
Are you an ex-smoker?	[ ] Yes	[ ] No	How much? _____	How long? _____
Do you drink?	[ ] Yes	[ ] No	How much? _____	How long? _____

ADVANCED PAIN MANAGEMENT CENTER
Pain Questionnaire

Have you ever used non-prescribed or illegal drugs (such as cocaine, heroin, Fentanyl, Marijuana, Percocet, Oxycontin, Vicodin) [ ] Yes [ ] No If yes, how long?_____

Patient Name: _____ Date: _____

Are you currently taking any medications? [ ] Yes [ ] No If yes, please list them below.

	Name of Medication	Strength	How many per day
1.			
2.			
3.			

Do you have allergy to any medications? [ ] Yes [ ] No

If "yes" to what are you allergic? _____

Are you married? [ ] Yes [ ] No

Do you have any children? [ ] Yes [ ] No How many? _____ Ages: _____

Have you ever had any surgical procedures? [ ] Yes [ ] No

	Name of Procedure	Year Performed	Name of Surgeon	Name of Hospital
1.				
2.				
3.				
4.				

Do you have you any medical conditions? (Example: *Asthma, high blood pressure, diabetes, arthritis, heart attack, diverticulitis*) Please list:

_____

_____

Do you have history of: [ ] Migraine [ ] Bleeding problems [ ] On anticoagulants

Do you have you any bleeding problem? [ ] Yes [ ] No

Are you on a blood thinner: [ ] Yes [ ] No

If yes: [ ] Coumadin [ ] Lovenox [ ] Plavix [ ] Ticlid [ ] Heparin [ ] Prodaxa [ ] Aspirin
[ ] Xarelto [ ] Other:_____

Have you had any imaging studies, if yes:

[ ] MRI Where _____ When _____

[ ] CT Scan Where _____ When _____

[ ] Xray Where _____ When _____

ADVANCED PAIN MANAGEMENT
3 WOODLAND ROAD
SUITE 322
STONEHAM, MA 02180

NAME:_____ DATE:_____

REVIEW OF SYSTEMS

First Visit – Mark all symptoms that pertain to you.

General: (*Mark all that apply – if no symptoms, please mark "none").*

Fever	___	Chills	___	Sweats	___
Appetite loss	___	Weight loss	___	"Feeling sick"	___
Fatigue (always tired)	___			None	___

Eyes: (*Mark all that apply – if no symptoms, please mark "none").*

Vision loss – 1 eye	___	Double vision	___	Eye irritation	___
Vision loss – both eyes	___	Blurring	___	Eye pain	
"Halos" around lights	___	Discharge	___	Light sensitivity	___
				None	___

Ears/Nose/Throat: *(Mark all that apply – if no symptoms, please mark "none").*

Ringing in the ears	___	Ear discharge	___	Earache	___
Decreased hearing	___	Nasal congestion	___	Nosebleeds	___
Difficulty swallowing	___	Hoarseness	___	Sore throat	___
				None	___

Cardiovascular: *(Mark all that apply – if no symptoms, please mark "none").*

Difficulty breathing at night	___	Near fainting	___	Chest pain or discomfort	___
Racing/skipping heart beats	___	Fatigue	___	Lightheadedness	___
Shortness of breath with exertion	___	Palpitations	___	Swelling of hands or feet	___
Difficulty breathing while lying down	___	Fainting	___	Leg cramps with exertion	___
Bluish discoloration of lips or nails	___	Weight gain	___	None	___

Respiratory: *(Mark all that apply – if no symptoms, please mark "none").*

Sleep disturbances due to breathing	___	Cough	___	Shortness of breath	___
Coughing up blood	___	Chest discomfort	___	Wheezing	___
Excessive sputum	___	Excessive snoring	___	None	___

Gastrointestinal: *(Mark all that apply – if no symptoms, please mark "none").*

Excessive appetite	___	Loss of appetite	___	Indigestion	___
Vomiting blood	___	Nausea	___	Vomiting	___
Yellowish skin color	___	Gas	___	Abdominal pain	___
Abdominal bloating	___	Hemorrhoids	___	Diarrhea	___
Change in bowel habits	___	Constipation	___	Dark Tarry stools	___
		Bloody stools	___	None	___

Please turn this page to continue on the other side.

NAME:_____ DATE:_____

Genitourinary: *(Mark all that apply – if no symptoms, please mark "none").*

Blood in urine	___			Foul urinary discharge	___
Kidney pain	___	Urinary urgency	___	Inability to empty bladder	___
Night time urination	___	Painful urination	___	Trouble starting urinary stream	___
Lack of sexual drive	___	Genital sores	___	Excessively heavy periods	___
Unusual urinary color	___	Missed periods	___	Other abnormal vaginal bleeding	___
None	___	Pelvic pain	___		

Musculoskeletal: *(Mark all that apply – if no symptoms, please mark "none").*

Joint swelling	___	Joint pain	___	Muscle cramps	___
Stiffness	___	Back pain	___	Presence of joint fluid	___
Gout	___	Arthritis	___	Muscle weakness	___
Muscle aches	___	Loss of strength	___	None	___

Skin: *(Mark all that apply – if no symptoms, please mark "none").*

Suspicious lesions	___	Night sweats	___	Excessive perspiration	___
Poor wound healing	___	Dryness	___	Change in nail beds	___
Itching	___	Skin Cancer	___	Unusual hair distribution	___
Rash	___	Flushing	___	Changes in color of skin	___
				None	___

Neurologic: *(Mark all that apply – if no symptoms, please mark "none").*

Headaches	___	Poor balance	___	Difficulty with concentration	___
Inability to speak	___	Numbness	___	Disturbances in coordination	___
Brief paralysis	___	Tingling	___	Falling down	___
Weakness	___	Seizures	___	Visual disturbances	___
Fainting	___	Tremors	___	Sensation of room spinning	___
Memory loss	___			Excessive daytime sleeping	___
				None	___

Psychiatric: *(Mark all that apply – if no symptoms, please mark "none").*

Thoughts of suicide	___	Anxiety	___	Sense of danger	___
Thoughts of violence	___	Depression	___	Mental problems	___
Frightening visions or sounds	___			None	___

Endocrine: *(Mark all that apply – if no symptoms, please mark "none").*

Heat intolerance	___	Cold intolerance	___	Excessive hunger	___
Weight change	___	Excessive thirst	___	Excessive urination	___
				None	___

Heme/Lymphatic: *(Mark all that apply – if no symptoms, please mark "none")*

Skin discoloration	___	Bleeding	___	Enlarged lymph nodes	___
Fevers	___	Abnormal bruising	___	None	___

Allergic/Immunologic: *(Mark all that apply – if no symptoms, please mark "none").*

Seasonal allergies	___	Hives or rash	___	Persistent infections	___
HIV Exposure	___			None	___

Reviewed:_____ **MD/NP/PA**

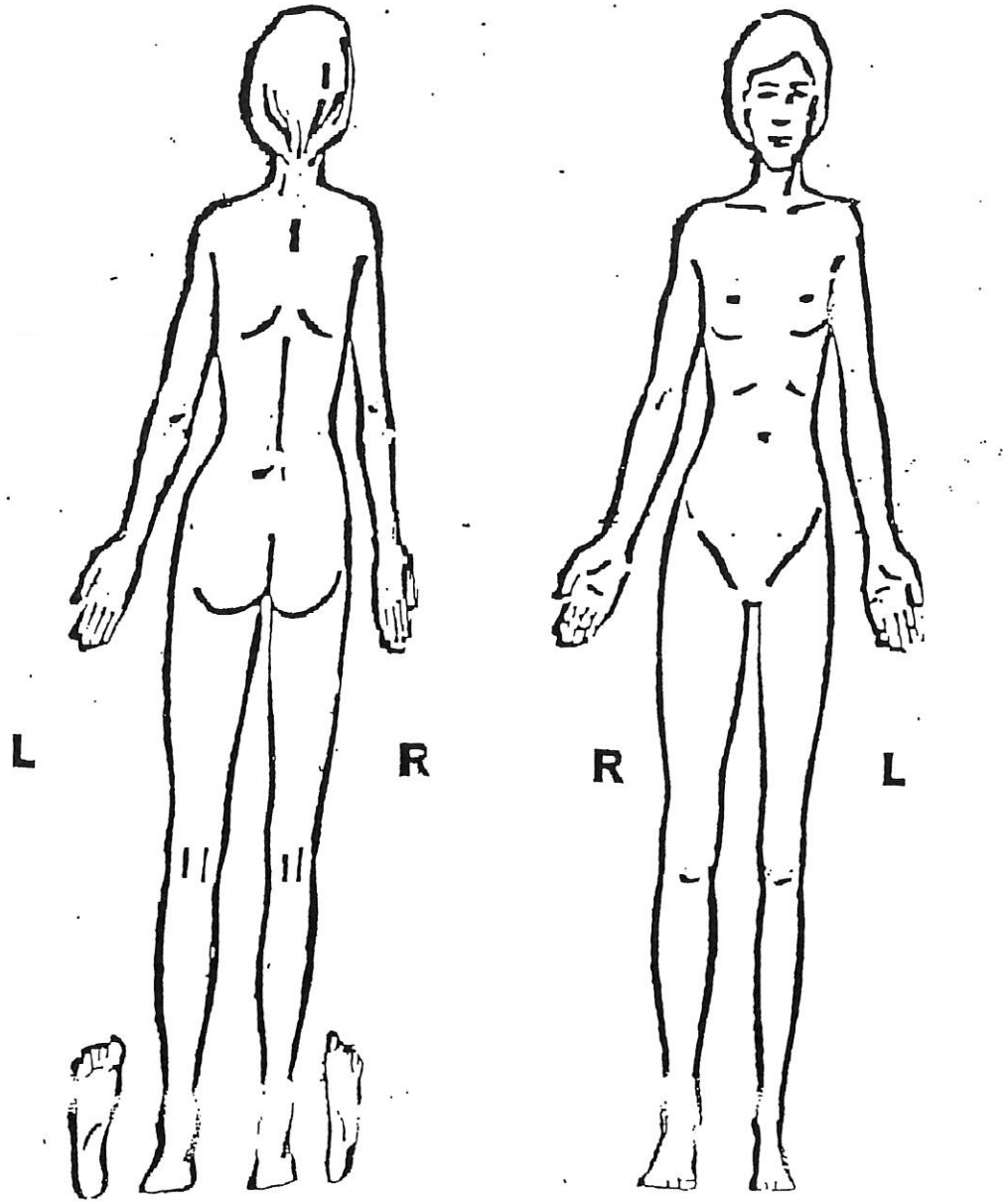
NAME: **PAIN DIAGRAM** DOB:

_____ _____

- **Mark the areas where you feel the described sensations**
- **Use the appropriate symbols**
- **Include all affected areas**

PAIN:

N N N N N	Dull Aching	X X X X X X X	Burning	= = = = = = =	Numbness
卌 卌 卌	Stabbing	• • • • • •	Pins & Needles	S S S S S S S S S	Muscular Cramp



ADVANCED PAIN
MANAGEMENT CENTER
3 WOODLAND ROAD
SUITE 322
STONEHAM, MA 02180
Phone (781-662-2243)

TO THE PATIENT:

BREAKING AN APPOINTMENT HINDERS OUR ABILITY TO CARE FOR YOU AS WELL AS OTHER PATIENTS. ALSO OUR EMPLOYEES SPEND VALUABLE TIME PREPARING FOR YOUR PROCEDURE/EMG.

IT IS YOUR RESPONSIBILITY TO NOTIFY THIS OFFICE AT LEAST 72 BUSINESS HOURS BEFORE YOUR SCHEDULED PROCEDURE/EMG. YOU MUST SPEAK TO OUR RECEPTIONIST. LEAVING A MESSAGE WITH THE ANSWERING SERVICE IS NOT ACCEPTABLE.

THERE WILL BE A CHARGE OF $200.00 DOLLARS FOR ANY PROCEDURE/EMG CANCELLED WITHIN LESS THAN 72 BUSINESS HOURS. THIS ALSO APPLIES TO NO-SHOWS.

THE CANCELLATION/NO-SHOW FEE OF $200.00 IS THE PATIENT'S RESPONSIBILITY. THIS IS NOT BILLABLE TO THE INSURANCE COMPANY. THIS FEE WILL HAVE TO BE PAID PRIOR TO YOUR NEXT OFFICE VISIT.

PATIENT SIGNATURE _____

NAME (PRINTED) _____

WITNESS _____

DATE _____

ADVANCED PAIN MANAGEMENT

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to Advanced Pain Management Center's (APM) use and disclosure of my protected health information ("PHI") in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate healthcare operations of the medical practice.

I understand that Advanced Pain Management's agreement to provide medical services to me is conditioned upon my signing of this consent and that APM requests my consent to ensure that APM can properly carry out the professional responsibility of caring for me.

I understand that APM will disclose only the minimum amount of my health care information which is necessary, in the judgment of APM, for the legitimate needs of the recipient or for my general well being.

My PHI, which is the subject of this consent, includes demographic information, information about my physical or mental health or condition, information about the medical services provided to me, including payment information.

I understand that I have a right to restrict APM's use and disclosure of my PHI and that APM is not obligated to agree to the requested restriction. I may revoke this consent at any time by providing APM with a written, signed, and dated request except to the extent that APM has acted in reliance upon my consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I understand that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with APM.

I acknowledge that APM reserves the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting the office staff at any time in writing.

_____ _____

Signature of Patient or Parent/Legal Guardian Date

_____

Printed Name

Advanced Pain Management Center

Anil Kumar, M.D., FACPM
Director

Financial Policy

Advanced Pain Management Center participates with most insurance plans including Worker's Compensation. You must have active health insurance coverage at each visit.

All past due balances are to be paid in full prior to further treatment unless other arrangements have been made.

Self-Pay patients must pay for their visit in full the same day. We accept cash, check or credit card (Visa, MasterCard, Discover and American Express).

- **Co-Pay and Deductible Payments are Due at the Time of Service.**
- **A Valid Referral Must be Obtained Prior to Your Visit. (Without a valid referral your appointment will be cancelled and/or rescheduled until the appropriate referral is obtained.)**
- **Payment Can be in the Form of Cash, Check, Credit/Debit Card or Money Order. Personal Checks Will be Electronically Debited from Your Account the Same Day – Electronic Funds Transfer (EFT).**

INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. We will NOT become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, and insurance take-backs, etc., other than to supply factual information, if necessary. You are responsible for timely payment of your account.

PPO/HMO/POS/EPO

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan and to obtain the appropriate referral or authorization for your visit. Verification of your insurance plan is required. Therefore, you must provide current insurance information and/or inform our office if there has been a change to your insurance plan or benefits.

Your signature below indicates that you have read and fully understand our Financial Policy. If you have any questions regarding this policy please contact the Billing Manager and she will be happy to assist you.

Signature:_____ Date:_____

Print Name:_____ Date:_____

3 Woodland Road, Suite 322, Stoneham, MA 02180 (781)662-2243 Fax: (781)662-4878
www.bostonpainspecialist.com

NORTHEAST AMBULATORY CENTER

CANCELLATION POLICY

TO THE PATIENT:

BREAKING AN APPOINTMENT HINDERS OUR ABILITY TO CARE FOR YOU AS WELL AS OTHER PATIENTS.

ALSO OUR EMPLOYEES SPEND VALUABLE TIME PREPARING FOR YOUR PROCEDURE.

IT IS YOUR RESPONSIBILITY TO:

1. NOTIFY THIS OFFICE AT LEAST 72 BUSINESS HOURS BEFORE YOUR SCHEDULED PROCEDURE IF YOU WISH TO RESCHEDULE YOUR PROCEDURE AND SPEAK TO OUR STAFF, LEAVING A MESSAGE WITH THE ANSWERING SERVICE IS NOT ACCEPTABLE.

2. HAVE A RESPONSIBLE ADULT TAKE YOU HOME AFTER THE PROCEDURE

THERE IS A CHARGE OF $200.00 FOR ANY PROCEDURE, WHEN:

1. CANCELLED LESS THAN 72 BUSINESS HOURS FROM THE DATE OF THE PROCEDURE.
2. NO SHOW.
3. NO RESPONSIBLE ADULT TO TAKE YOU HOME AFTER THE PROCEDURE.

THE CANCELLATION FEE OF $200.00 IS YOUR RESPONSIBILITY. THIS FEE IS NOT BILLABLE TO THE INSURANCE COMPANY. THIS FEE MUST BE PAID BEFORE YOUR NEXT OFFICE VISIT.

PATIENT SIGNATURE _____

NAME (PRINTED) _____

WITNESS _____

DATE _____

7/2013

Northeast Ambulatory Center

Anil Kumar, M.D., FACPM
Director

Financial Policy

Northeast Ambulatory Center participates with most insurance plans including Worker's Compensation. You must have active health insurance coverage at each visit.

All past due balances are to be paid in full prior to further treatment unless other arrangements have been made.

Self-Pay patients must pay for their visit in full the same day. We accept cash, check or credit card (Visa, MasterCard, Discover and American Express).

- **Co-Pay and Deductible Payments are Due at the Time of Service.**
- **A Valid Referral Must be on File with Advanced Pain Management Prior to Your Procedure.**
- **Payment Can be in the Form of Cash, Check, Credit/Debit Card or Money Order. Personal Checks Will be Electronically Debited from Your Account the Same Day – Electronic Funds Transfer (EFT).**

INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. We will NOT become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, and insurance take-backs, etc., other than to supply factual information, if necessary. You are responsible for timely payment of your account.

PPO/HMO/POS/EPO

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan and to obtain the appropriate referral or authorization for your visit. Verification of your insurance plan is required. Therefore, you must provide current insurance information and/or inform our office if there has been a change to your insurance plan or benefits.

Your signature below indicates that you have read and fully understand our Financial Policy. If you have any questions regarding this policy please contact the Billing Manager and she will be happy to assist you.

Signature:_____ Date:_____

Print Name:_____ Date:_____

3 Woodland Road, Suite 321, Stoneham, MA 02180 (781)665-5233 Fax: (781)662-1497
www.bostonpainspecialist.com

ORT Patient Form

Name_____ **Date**_____

Mark each box that applies		Female	Male
1. Family history of substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	• Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia • Depression	[ ] [ ]	[ ] [ ]

ADVANCED PAIN MANAGEMENT CENTER

Controlled Substance Agreement

Opioids and other controlled substances are used in the management of chronic pain and related conditions all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the healthcare provider by establishing guidelines, within the laws, for proper controlled substance use.

1. All controlled substances have a potential for dependence and abuse.
2. All controlled substances must be prescribed only by the healthcare provider at Advanced Pain Management Center unless specific authorization is obtained for an exception.
3. 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:

   _____ Phone:_____
4. When a "pill count" is requested, you must come to this office and bring the medicine bottle with all the pills before 3:00 p.m. the same day. Failure to comply with "pill count" requirement will result in termination of narcotics agreement.
5. You may not share, sell, or otherwise permit others including spouse or family members to have access to these medications.
6. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may result in your discharge from the facility.
7. **You will not consume alcohol in conjunction with narcotics**, nor will you use, purchase, or otherwise obtain any illegal drugs.
8. Medications or prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced.
9. 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.
10. Early refills will not be given. Renewals are based upon keeping scheduled appointments. **Please do not phone for prescriptions after hours or on weekends.**
11. In the event you are arrested or incarcerated related to legal or illegal drugs, you must notify us. Controlled substances will not be given.
12. If a female of childbearing age, you certify that you are not pregnant and that you will use appropriate measures to prevent pregnancy during the course of treatment with controlled substances. You understand that unannounced pregnancy testing may be requested and your cooperation is required.
13. Any altered or forged prescriptions, or any attempt to sell or give my medication to somebody else will cause this agreement to be cancelled.
14. **You understand that the use of narcotics may impair judgement, vision, response time, and may make it unsafe to drive an automobile or operate heavy equipment/machinery.**
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by the healthcare provider at Advanced Pain Management Center.
16. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its items.
17. **If you choose to "Partial Fill" a narcotics prescription, you shall not be given any prescription for the balance.**

_____ _____

Patient Full Name (Print) Patient Signature

_____ _____

Physician/Nurse Practitioner Signature Date

1/2017