

APM New Patient Packet

Suboxone

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: <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
OCCUPATION: (CURRENT OR PREVIOUS)		EMPLOYER:	

ETHNICITY & RACE (REQUIRED BY THE STATE)

<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> American Indian	Other:
Who Referred You to this Office? <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> 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

PATIENT NAME: _____

DOB: _____

SUBOXONE TREATMENT QUESTIONNAIRE

Reason for seeking treatment

Drug Use: (Cocaine, Oxycodone, OxyContin, Vicodin, Percocet, Heroin)

How Long Using? _____ What Route? (Mouth, IV, Sniff) _____

How Much? _____ How Often? _____

Has your drug use ever resulted in medical or legal problems? () N

() Y _____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? () N

() Y (Please describe setting, length) _____

Have you ever tried to quit on your own? () N

() Y (Please describe setting, length) _____

Have you ever been treated by a psychiatrist? () N

() Y (Please describe treatment reason, setting, and length)

PATIENT NAME: _____

DOB: _____

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle or grandparent) have a history of drug abuse? () N

() Y _____

Have you been tested for Hepatitis B, C, HIV [] Yes [] No

Do you have any medical conditions (diabetes, HIV+, epilepsy, STDs)? () N

() Y _____

Are you currently taking any medications to treat these conditions? () N

() Y (List medication and dosage)

Are you pregnant? () N/A () N () Y () Not Sure

Are there any current legal issues we should be aware of (probation, parole)? () N

() Y _____

Are you currently employed? () N () Y How many hours/week (avg.)?

Please describe your current living arrangements _____

Other _____

Patient Signature

Date: _____

Advanced Pain Management
3 Woodland Road, Suite 322
Stoneham, MA 02180
Phone: 781-662-2243
Fax: 781-662-4878
Email: apm@painpro.com

METHADONE TRANSFER CONSENT

I _____ authorize _____
Patient Name (Print) Physician Name (Print)

practicing at the above address to disclose my treatment for opioid dependence to the outpatient treatment program specified below in order to obtain my medical history, methadone treatment, and any other of my patient information pertinent to the office-based treatment with buprenorphine. I understand that the physician mentioned above may need to discuss my medical and treatment history with the physicians and other staff at the outpatient treatment program specified below.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____	_____	
Patient Signature	Date	
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Name (Print)	Date
_____	_____	_____
Witness Signature	Witness Name (Print)	Date

Outpatient treatment program: Name _____
Phone _____
Address _____

Confidentiality of Alcohol and Drug Dependence Patient Records
The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a

patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Patient Name:
 DOB:
 CHB ID:

Agreement for Treatment with Suboxone

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. I agree to keep all of my ASAP appointments. If I must reschedule an appointment I will call the ASAP office as soon as I am aware of the need to change.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. I will report my history and symptoms honestly to ASAP staff. I will inform ASAP staff of all my other doctor and dentist appointments, and any medications (prescription or non-prescription) that I am taking. I will report any change in my medical history, such as becoming pregnant or developing hepatitis C.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. I will tell the ASAP staff if I have used alcohol or street drugs before a drug test result shows it.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. I agree to cooperate with urine drug testing whenever requested by ASAP staff, to detect whether I have used alcohol, prescription drugs, or street drugs.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. I understand that buprenorphine (as found in my medication, Suboxone) is a narcotic drug that can produce a 'high'. I know that taking buprenorphine regularly can lead to physical dependence and that if I abruptly stop taking it I could experience symptoms of opioid withdrawal.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	6. I will take Suboxone by placing it under my tongue to dissolve and be absorbed. I will never inject Suboxone or take it IV because IV use could lead to sudden and severe opiate withdrawal.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	7. I understand that Suboxone is a powerful drug. People who want to get high or sell Suboxone for a profit may want to steal my take-home prescription supplies. My medication must be protected from theft or unauthorized use. If my medications are stolen, I will file a report with the police and bring a copy to my next ASAP visit.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. I agree that my home supplies of Suboxone will be kept in the care of my parent or guardian.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	9. I understand that Suboxone must be stored safely, where it cannot be taken accidentally by children or pets, or stolen. If anyone else takes my Suboxone I will call 911 or Poison Control at 1-800-222-1222 immediately.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. I will be careful with my take-home prescription supplies of Suboxone. If I report that my supplies have been lost or stolen my doctors will not provide me with make-up supplies. I understand that if I run out of my medication before it is time for a refill I could end up experiencing symptoms of opiate withdrawal.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	11. I will bring my bottle of Suboxone in with me for every appointment with my ASAP Clinician for a pill count. I understand that I will not get a refill prescription at my visit if I do not bring my pill bottle with me.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	12. I will take my Suboxone as prescribed. I will not skip doses or adjust the dose without talking with my ASAP doctor.

Patient Name:
 DOB:
 CHB ID:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	13. I will not drive a motor vehicle or use power tools or other dangerous machinery while taking Suboxone until my ASAP doctor has cleared me to do so. I understand that I will be evaluated to resume driving after I have been on a stable dose of Suboxone for at least one month.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	14. My parent or guardian will accompany me to all of my Suboxone appointments until I am on a stable dose of medication and have been cleared by my ASAP doctor to drive or transport myself.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. I understand that it can be dangerous to mix Suboxone with alcohol or other sedatives (such as Valium, Ativan, Xanax, Klonopin)—so dangerous that it could result in accidental overdose, over-sedation, coma, or death . I agree to abstain from ALCOHOL and SEDATIVES while I am being treated with Suboxone. My ASAP doctor will discontinue my Suboxone treatment if I violate this agreement.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. I am not pregnant, and I will not have unprotected sex or attempt to become pregnant while taking Suboxone, because the safety of this medication during pregnancy is unknown. If I accidentally become pregnant I will inform the ASAP team as soon as I am aware so that they can refer me to a methadone clinic or for other appropriate treatment.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	17. I agree that medication management of addiction with Suboxone, is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling as recommended by ASAP staff, while being treated with Suboxone.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. I agree to abstain from all drugs, including alcohol, marijuana and other street drugs. I understand that continued use of drugs can interfere with my attempts at recovering from opioid dependence. I also understand that buprenorphine (as found in Suboxone) is designed to treat opioid dependence, not addiction to other classes of drugs. Therefore, I will work with ASAP to design an individualized treatment program to assist me in discontinuing the use of other drugs.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	19. I agree that professional counseling for addiction has the best results when patients also are open to support from peers who are pursuing recovery, and as such I agree to participate in a regular program of peer/self-help, as recommended by the ASAP staff to suit my individual needs, while being treated with Suboxone.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	20. I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment at ASAP.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. I agree that a network of support is an important part of my recovery, and honest communication among people within the network is important for my treatment. I will provide authorization to allow telephone, email, or face-to-face contact, between ASAP staff and physicians, therapists, probation officers, and parents to discuss my treatment and progress.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	22. I have been given a copy of the ASAP information sheet which includes hours of operation, clinic phone number and emergency contact information.

Patient Name:
DOB:
CHB ID:

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____

I agree with all of the statements on this page. By my signature above, I further agree that I will closely monitor my child for 24 hours before the first scheduled dose of Suboxone. If my child does not cooperate with monitoring I will inform ASAP staff prior to administering the first dose of medication.

ASAP Staff Signature/Title: _____ Date: _____

**ADVANCED PAIN MANAGEMENT
WAIVER OF MEDICAL INSURANCE**

I am fully aware that my medical insurance may pay for this treatment. I waive my right to bill my medical insurance and choose to pay for my treatment for services rendered at this office for initial visit and ongoing care.

I understand signing this agreement allows this office to bill me for any and all treatment and I will be financially obligated to any balance.

_____ **Date** _____

_____ **Date** _____
Witness

Advanced Pain Management
3 Woodland Road, Suite 322
Stoneham, MA 02180
Phone: 781-662-2243
Fax: 781-662-4878
Email: apm@painpro.com

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize _____ at the above address to:
Patient Name (Print) Physician Name (Print)

MD check all that apply

- Receive my medical history information from the following physicians:
(name, address) _____
(name, address) _____
- Receive my treatment records from the following therapist
Therapist (name, address) _____
- Release my treatment information/records to the following healthcare professional
(name, address) _____
- Release my treatment information to the health insurance company listed below for billing purposes
Insurance Provider (name, address) _____

This information is for the following purposes (any other use is prohibited): _____

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I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Witness Signature

Witness Name (Print)

Date

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1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

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ADVANCED PAIN MANAGEMENT
3 WOODLAND ROAD, SUITE 322
STONEHAM, MA 02180
PHONE: 781-662-2243
FAX: 781-662-4878
EMAIL: APM@PAINPRO.COM

PATIENT TREATMENT CONTRACT

Patient Name _____ Date _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium[®], Klonopin[®], or Xanax[®]), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
- 13.

I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

_____ Date _____
Patient Signature

*Valium[®] is a registered trademark of Roche Products Inc.

†Klonopin[®] is a registered trademark of Roche Laboratories Inc.

‡Xanax[®] is a registered trademark of Pharmacia & Upjohn Company

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APPOINTED PHARMACY CONSENT

SUBOXONE® [Ⓒ] (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet
SUBUTEX® [Ⓒ] (buprenorphine HCl) sublingual tablet

I _____ do hereby: **(MD check all that apply)**
Patient Name (Print)

Authorize _____ at the above address to disclose my treatment for opioid
Physician Name (Print)

dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

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I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print) Date

Witness Signature

Witness Name (Print) Date

Appointed Pharmacy: Name _____ Phone _____
Address _____

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TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give _____
Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):
 Home _____
 Work _____
 Cell _____

Yes, this office may leave (check all that apply):
 Voice mail at my Home Voice mail at my Work Voice mail on my Cell
 Messages with people at my Home Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print) Date

Witness Signature

Witness Name (Print) Date

**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: _____

ORT Patient Form

Name _____ Date _____

Mark each box that applies		Female	Male
1. Family history of substance abuse	<ul style="list-style-type: none"> • Alcohol • Illegal drugs • Prescription drugs 	[]	[]
2. Personal history of substance abuse	<ul style="list-style-type: none"> • Alcohol • Illegal drugs • Prescription drugs 	[]	[]
3. Age (mark box if 16-45 years)		[]	[]
4. History of preadolescent sexual abuse		[]	[]
5. Psychological disease	<ul style="list-style-type: none"> • 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