



Patient Demographics

Patient Information:

Last Name:		First Name:		Middle Initial:
How did you learn about our practice? <input type="checkbox"/> TV Commercial <input type="checkbox"/> Advertisement <input type="checkbox"/> Friend <input type="checkbox"/> Physician <input type="checkbox"/> Other				
DOB: / /	Age:	Social Security Number: - -		
Mailing Address: Street:		Street Address (if different from Mailing): Street:		
City:	State:	Zip:	City:	State: Zip:
Home Phone:		Cell Phone:	Work Phone:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> American Indian/ Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multi				
In case of an emergency, who should we notify? Name:				Phone:
Primary Care Physician:		Primary Care Physician Phone Number:		
Patient Employed by:				
Employer Address: Street:		Employer Phone Number:		
City:	State:	Zip:		
Spouse Name:		Spouse Date of Birth:		
Spouse Employed by:		Spouse Social Security Number: - -		

Insurance Information:

Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Primary Insurance:		
Policy Number:		Group Number:		
Subscribers Name:		Subscribers Date of Birth: / /	Subscribers SS#:	
Subscribers Employer:				

Related to Your Condition:

Is your condition related to employment (current or previous)? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Date of Injury: / /	
Are the injuries for which you are seeking treatment the result of a motor vehicle collision or other personal injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes to above, please describe: 			
If yes, date of injury: / /		-Who is the at-fault party? -Party's Ins. Carrier?	
- If yes, Are you represented by an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, Attorney's Name, Address, Telephone: 		- If yes, has a lawsuit been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, which court? <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Superior <input type="checkbox"/> Magistrate - If yes, what state/county? 	

Patient Signature: _____

Date: _____

Office Use Only: Information Verified by: _____ Date: _____
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Vital Signs

(Nurse's use, this section only)

T: _____ BP: _____ HR: _____

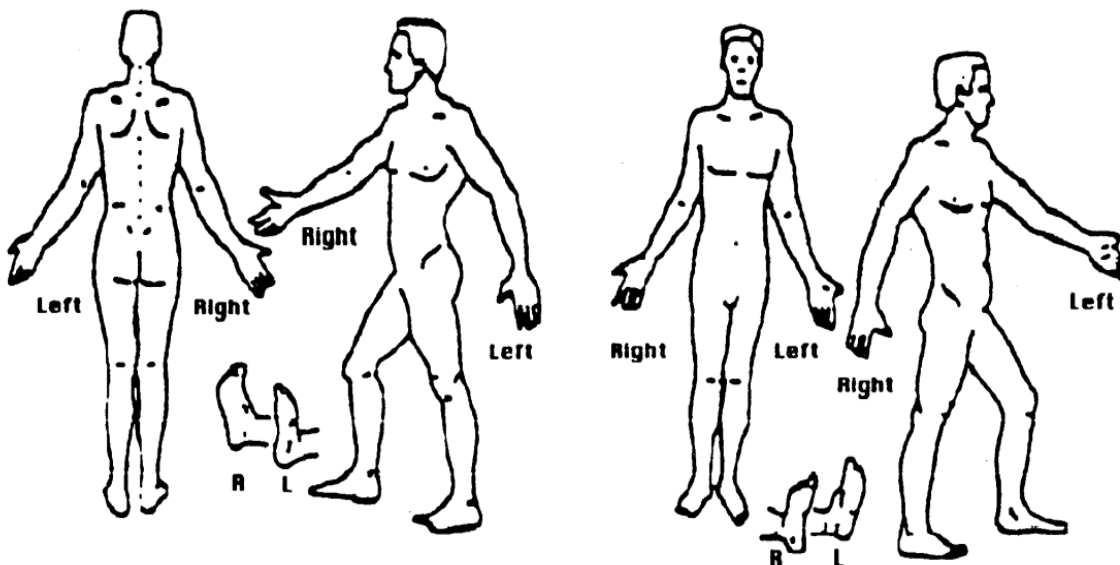
Today's Date: _____/_____/_____

The Spine Center of Southeast Georgia

New Patient Intake Questionnaire

Name: _____ Age: _____ Height: _____ Weight: _____

1. Are you right or left handed? (Circle one)
2. Date of accident or onset of problem: _____
Is your problem or injury work related? Yes/No If no, go to #4.
3. Activity (job) you were performing when the accident occurred: _____
4. Is your accident or injury due to a motor vehicle accident? Yes/No
If no, go to #5. If yes:
 Were you the driver, front passenger, rear passenger, or pedestrian? (Circle one)
 Were you wearing a seat belt? Yes/No
 Were you hit from the back, front, driver, passenger, or driver side? (Circle one)
 How fast was your car traveling? _____
 How fast was (were) the other car(s) traveling? _____
5. Please describe how the accident or injury occurred: _____
6. Did you hit your head? Yes/No
 Did you lose consciousness (pass out)? Yes/No
 Have you lost control of your bowel or bladder? Yes/No
7. Where is your pain or injury? _____
 When did you first notice the pain or injury? _____
 Do you have headaches? Yes/No Are you having difficulty sleeping? Yes/No
8. Please mark the figure with the location of your symptoms.
 PAIN = X **NUMBNESS/TINGLING = O**



Please mark the following scale to show the **intensity of pain** that you are having:

least 0 - - - - | - - - - | - - - - | - - - - | - - - - **5** - - - - | - - - - | - - - - | - - - - | - - - - **10 most**

9. What position(s) or activity(ies) increase your pain? (Circle all that apply)
Standing Sitting Lying Walking Twisting Driving Reaching Other:

What position(s) or activities reduce your pain? (Circle all that apply)
Standing Sitting Lying Walking Twisting Driving Reaching Other:

About how much weight can you comfortably lift?

10. Did you go to an Emergency Room following the onset of your pain or problem? Yes/No If yes:
When? _____ Which hospital? _____ Did you go by ambulance? Yes/No
Were X-rays taken? Yes/No
If yes, which body parts? _____
What treatments or medications were given? _____

11. Have you been to see other physicians or chiropractors for this problem or injury? Yes/No
If yes, please list name(s), date(s), and any treatment(s) provided: _____

12. Have you had any physical therapy for this pain or injury? Yes/No
If yes, how many sessions? _____

13. Have you missed any work as a result of this pain or injury? Yes/No
If yes, list dates: _____
Do you have any work restrictions? Yes/No
If yes, please list: _____

14. Have you ever had a similar injury in the past? Yes/No
If yes, please describe: _____

15. Have you ever had any of the following tests or treatments?
(Please circle and provide **dates** and **locations** of tests or treatments.)

- MRI _____
- CT Scan _____
- EMG _____
- Nerve Conduction Studies _____
- Myelogram _____
- Bone Scan _____
- Discogram _____
- Trigger Point Injections _____
- Epidural Cortisone Injection _____
- Neck or Back Surgery _____
- Other: _____

Patient Signature: _____ **Date:** _____

PAST MEDICAL HISTORY

16. Have you ever been diagnosed with any of the following medical problems?
(Circle all that apply.)

Hepatitis AIDS/HIV Diabetes High Blood Pressure STD
Lung Disease Heart Disease Emotional Disorder Asthma Depression
Cancer Anxiety Tuberculosis Ulcers Other: _____

I have none of the above and no other medical problems. (Circle if correct)

17. Have you been hospitalized within the last year? Yes/No
If yes, why? _____

18. Have you ever had major trauma? Yes/No
If yes, please describe: _____

19. Please list any additional surgeries you have had: _____

20. Please list all prescription medications you are currently taking: _____

21. Are you taking any of the following medications? (Circle all that apply)

BC Powder Ibuprofen Advil Aleve Aspirin Goodies Powder
Coumadin Plavix Naprosyn Ecotrin Nuprin

22. Do you have any of the following allergies? (Circle all that apply)

Sea Food Codeine Aspirin Penicillin
Sulfa Novocain IVP Dye Other: _____

FAMILY HISTORY

23. Mother/Father/Siblings (Circle all that apply)

Heart Attack Stroke Diabetes Hypertension Depression

Cancer (type) _____ Other: _____

Patient Signature: _____ **Date:** _____

SOCIAL HISTORY

24. Are you single, married, widowed or divorced? (Circle one)
If you have children, how many do you have?
Do you have any close friends or family members who are disabled? Yes/No
Do you smoke tobacco? Yes/No
If yes, how many years have you smoked? _____
How many cigarettes per day? _____
Do you drink alcohol? Yes/No
How much per week? _____
Please describe your education: Grade school, HS degree, GED, trade school, college, post-graduate?
(Circle)
What is your current job or occupation? _____
25. Have you felt you should cut down on your drinking or medication usage? _____
Have people annoyed you by criticizing your alcohol or medication use? _____
Have you felt bad or guilty about your drinking or medication use? _____
Have you ever had a drink or taken medication first thing in the morning to steady your nerves or to get rid of a hangover? _____
26. Have you or any member of your family had a problem with alcohol or drug abuse? _____
27. Have you ever considered harming yourself or committing suicide? _____

REVIEW OF SYSTEMS

Please circle if you have any of the following:

Unplanned weight loss	Fever	Double vision
Ringing in the ears	Dizziness	Shortness of breath
Bloody sputum	New onset wheezing	New cough
Vomiting	Bowel or bladder Incontinence	Diarrhea
Urinary retention	Recent hearing loss	Recent vision change
Blood in the urine	Growing lumps	Chest pain
Recent pigment change in the skin	Finger nail changes	Fainting
Seizures	Memory loss	Heat or cold intolerance
Recent change in urinary pattern	Suicidal thoughts	IV drug abuse
Recent change in appetite or thirst	Spontaneous bleeding	Spontaneous bruising
	None of the above	

Patient Signature: _____ **Date:** _____



The Spine Center of Southeast Georgia

NO SHOW POLICY

Patients must provide at least 24 hours prior notice if they need to cancel a scheduled office visit, otherwise the patient will be considered a "no-show"
Prior notice is defined as telephoning the clinic offices during regular business hours (8:15 a.m. to 5:00 pm, Monday through Friday, except holidays) to inform the clinic of the patient's unavailability to make a scheduled appointment.
If a patient no-shows for an office visit, the patient's account will be assessed a \$25 no-show fee.
The patient will not be rescheduled until the no-show fee has been satisfied and cleared from the patient's account.
No further prescriptions will be written, called-in or authorized until the patient is examined by one of the physicians at a rescheduled appointment.
If a patient no-shows for an appointment more than two times in a calendar year, the patient may be considered for dismissal from the practice.

PATIENT RECORD OF DISCLOSURE HIPAA Privacy Rule

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's homes. Copies of the Notices of Privacy Practices are available at the front desk.

Please answer the following questions regarding your PHI, this information will be used for The Spine Center of Southeast Georgia as well as Brunswick Pain Treatment Center:

Last Name:	First Name:	Date of Birth: / /
Who may we speak with regarding your Protected Health Information? (Please list all persons you trust regarding your health information)		
Name: _____		
Relationship: _____		
Please list your home telephone number: () -		
Choose from following:		
<input type="checkbox"/> Permission to leave a detailed message		
<input type="checkbox"/> Permission to leave message with call-back number only		
<input type="checkbox"/> Permission to leave message with the above named persons		
Written Communication: Do we have permission to mail correspondence to your house? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate any other specific instructions:		

Patient Signature: _____

Date: _____



Mark Gold, M.D., F.A.C.S.
Board Certified in Neurological Surgery
Gary Kaufman, M.D., F.A.C.S.
Board Certified in Pain Medicine
Board Certified in Neurological Surgery
Daryl Madden, PA-C
Diane Metzger-Commisso, PA-C
Matthew Boothby, PA-C

PATIENT FINANCIAL POLICY

THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT YOUR PAYMENT OBLIGATIONS PLEASE READ CAREFULLY

- COPAYS:** All Copays are collected **prior** to the visit. If you are not prepared to make your Copay, your visit will be rescheduled.
- SELF PAY:** All visits to the doctor will require payment at the time services are rendered or your visit will be rescheduled. No surgery will be scheduled until financial arrangements have been approved with the billing department.
- WORK COMP:** Patients covered under worker's compensation claim have no payments to make at the time of visit, unless the visit has not been pre-authorized.
- FEES:** The fees we charge for services are usual and customary for this area. Your policy may base its allowances on a fixed fee schedule that may not coincide with the current standard and cost of care in this area. You should be aware that different companies vary greatly in the types of coverage available.
- BALANCE:** All balances, after insurance has been processed, are **due, in full, within 30 days.**
- COLLECTIONS:** Any patient account that has been placed in collections must pay any prior balance owed to the practice and the collection agency fee in cash before the practice will see you again.

You understand, regardless of your insurance status, you are ultimately responsible for the balance of your account with us for the professional services rendered by The Spine Center of Southeast Georgia. Furthermore, you understand that if your insurance company or any other payor (including government programs) denies payment on your account for any reason, you are responsible for the total costs of any service(s) rendered. Patients are responsible for knowing which facilities are participating (in-network) with their insurance carrier specific to Doctors' office visits, outpatient treatments, etc.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

If you do not agree/sign to this Financial Policy, we will gladly provide you with a copy of each visit's encounter for you to submit to your insurance company. In addition, your account will be classified as "self pay" with payment due at the time of check-in.



Assignment of Benefits Form & Release
The Spine Center of Southeast Georgia

I, the undersigned, hereby authorize the assignment of the benefits and rights available to me under my insurance plan with the insurance company listed on the copy of the current insurance card I have provided to The Spine Center of Southeast Georgia (hereinafter "Spine Center") for medical services and care provided to me by the Spine Center. I certify that the insurance information I have provided to the Spine Center is true and accurate and that I am responsible for keeping said information updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that the charges for the professional services and care rendered to me by the Spine Center (hereinafter "charges") are paid in full. I also understand that my insurance company may not pay at 100% of the amount of the charges and that I may be responsible for any and all charges not paid to the Spine Center by my insurance company, including any portion paid and not applied to in-network benefits for any out-of-network services. I agree to pay the full amount of any and all charges pursuant to the Spine Center's scheduled rates, copies of which are available to me upon request prior to treatment.

I authorize the Spine Center to release (1) information necessary to secure payment of benefits and/or (2) records of any treatment or examination rendered to me to other medical providers. This information may relate to (a) age; (b) medical history, condition, and/or care; (c) physical and/or mental health; (d) occupation; (e) income; (f) avocations; (g) driving records; and/or (h) other personal characteristics. This authorization extends to information on the use of alcohol, drugs and/or tobacco; the diagnosis and/or treatment of HIV infection and other sexually transmitted disease(s); and the diagnosis and/or treatment of mental illness.

I authorize the Spine Center to submit claims on my behalf to my insurance company. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure that all charges are paid in full. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

I irrevocably designate, authorize and appoint the Spine Center as my true and lawful attorney-in-fact. This power of attorney is provided for the limited purpose of receiving all payments due under my insurance plan on account of medical services and care rendered or to be rendered to me by the Spine Center. This power of attorney shall automatically terminate, without formal action being taken, as soon as the Spine Center has received payment in full for all charges. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I authorize my insurance company to assign and transfer any and all of my applicable plan benefits and rights to the Spine Center, including the right to receive any applicable plan documents and remedies and to pursue appeals and/or litigation on my behalf. This authorization includes any rights due me permissible under state and federal laws.

I instruct and direct my insurance company to pay the Spine Center directly. I understand that under ERISA, I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the Spine Center; under my rights per state and federal ERISA regulations, I instruct and direct my insurance company to provide SPD documentation stating such non-assignability clause to me and the Spine Center. Upon proof of non-assignability, I instruct my insurance company to make the check out to me and mail it directly to the Spine Center for the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges. I agree and understand that any funds I receive from my insurance company for services and care rendered by the Spine Center will be immediately signed over and sent directly to the Spine Center. If my insurance company sends a check for payment directly to me, I agree to immediately deliver the check to the Spine Center, as I understand that the Spine Center has the right to immediate possession of the check.

This is a direct assignment of my rights and benefits under my insurance policy. I have agreed to pay any balance of the charges over and above any such insurance payment. I authorize the Spine Center to receive any checks from my insurance company on my account, endorse them for deposit, and deposit and apply the proceeds toward payment on my account. I further authorize the Spine Center to deposit checks received on my account when made out to me.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case. I authorize the Spine Center to be my personal representative, which allows it to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled; (2) submit any and all requests for benefit information from my insurance company; and (3) initiate formal complaints to any state and/or federal agency that has jurisdiction over my benefits.

I understand and agree that I am responsible for full payment of the total charges if my insurance company has refused to pay 100% of my benefits based on billed charges within ninety days of any and all appeals or requests for information. Should my account be referred to an attorney or outside agency for collection, I agree to pay to the Spine Center reasonably attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the maximum rate of 1 1/2 percent per month under O.C.G.A. § 7-4-16, or the highest legally available rate, whichever is higher. I understand and agree that fines levied against my insurance company will be paid to the Spine Center for acting as my personal representative.

I authorize the Spine Center and its associates to provide medical care and treatment to me by today's standards. Any action stemming from this Assignment of Benefits Form & Release shall be instituted, prosecuted, and maintained in Glynn County, Georgia. A photocopy of this Assignment of Benefits Form & Release shall be considered as effective and valid as the original. If any part or provision of this Assignment of Benefits Form & Release should be held void or invalid, the remaining provisions shall remain in full force and effect.

Signature of patient/Guarantor

Date

Signature of Policy Holder

Date

Witness



Informed Consent for Medical Office Procedures and Treatments

The physicians and staff of The Spine Center of Southeast Georgia are pleased that you have selected us to help you with your health concerns. The information you provide for us and the examinations and tests performed are all used to determine the most likely diagnosis for your problem. The diagnosis may be difficult to determine at first as many problems present in a similar manner. Tests that are more difficult to perform and may have the possibility of complications are usually not recommended until they are necessary to help determine the cause of your problems.

The treatments are selected to help you cure or improve your health problem. No treatment is 100% effective for all patients and all treatments have some potential for complications. We try to select the best treatment with the least potential for complications. Many of the treatments are selected from successful experience in using them. Others are recent improvements that have been successful in medical trials. It is not uncommon for physicians to prescribe different therapies for the same condition and get essentially identical results. There are alternatives for treating some problems, such as herbal remedies and acupuncture, in which physicians may have limited experience or the medical studies may be inadequate or contradictory such that the physician would not recommend these as a first choice of treatment.

It is important to understand that complications can occur with even the simplest treatment. Anything that enters the body has the potential of a very serious reaction. Some people will die from a bee sting or just eating a peanut if they have a serious allergy to either of these. Unfortunately, no one knows if they have allergies to any food, drug, or other chemical until they have a reaction. If these reactions are severe, they will cause rash, swelling, and sometimes difficult breathing. Therefore, it is important to inform your physician of any and all adverse medication reactions that you have experienced in the past. It is also very important to tell your physician and pharmacist all medications that you are currently taking because some medications may react with other medications in a bad way.

If medication reactions occur, seek medical help. If severe swelling or shortness of breath or wheezing should occur, one should go to the nearest medical emergency facility and even call 911 if necessary. Do not take any more of the medication and be sure to tell the prescribing physician and pharmacy that filled the prescription about the reaction. Any type medications (pills, liquids, creams, suppositories or injections) can cause reactions. In all cases, notify your physician immediately. If the prescribing physician is not available, other physicians or members of the office staff will be able to assist you when you call. If after business hours or on week-ends, call 911 or contact your local hospital.

This information is provided to help you decide if you wish to receive the treatment or tests recommended with the knowledge of these potential complications. By signing this you are giving your consent and permission for the physicians and staff to prescribe and perform treatments and tests they recommend for your health needs. This informed consent will be kept on record and considered active for all treatments following the date of your signature. This will apply to any treatments and recommended tests should they occur in this office, as a result of a phone call from you or at the hospital or emergency facility when any physician or one of the staff of this office provides the service. A copy will be provided for you at any time upon your request.

You always have the right to not take any prescription or refuse any procedure or test even if you have previously consented to it. The alternative for not accepting the treatment prescribed and doing nothing is that the condition may get worse, stay the same or possibly get better on its own. As mentioned before, there usually are alternative treatments available for your particular problem.

I understand that taking certain medications while pregnant can cause serious birth defects or even the death of my unborn child and I will notify my physician immediately if I attempt to become or do become pregnant.

I understand that the use of controlled substances may alter my ability to safely drive a motor vehicle.

I have read or have had read to me this informed consent. I have had an opportunity to ask questions regarding this consent and any potential benefits or complications that can result from treatments or tests ordered by my physician. I understand the information in this informed consent.

Print Name

Signature of Patient

Date

Witness

Date



Mark Gold, M.D., F.A.C.S.
Board Certified in Neurological Surgery

Gary Kaufman, M.D., F.A.C.S.
Board Certified in Pain Medicine
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Controlled Substance Agreement and Informed Consent Form

This contract outlines some important requirements that I must fulfill in order to participate in the Chronic Pain Treatment Program. This agreement relates to my use of any controlled substance(s) (i.e. narcotics, painkillers, and prescription medications) for chronic pain prescribed by Dr. Kaufman, Dr. Gold and/or any authorized assistant(s). I understand that there are federal and state laws that guide our policies regarding the use and prescription of controlled substance(s). The Georgia State Board of Medical Examiners and the Georgia State Board of Pharmacy all have specific requirements for the use of controlled substance(s) for the treatment of chronic pain and, and we do adhere to their rules and regulations.

The Doctors and /or any appropriately authorized assistant(s) may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and, if the narcotics are not **improving my quality of life**, the narcotics will be discontinued.

I hereby authorize and give my voluntary consent for treatment and evaluation to the doctors and/or any appropriately authorized assistant(s) as an element in the treatment of my chronic, intractable pain.

The therapies necessary to treat my chronic pain have been explained to me and I understand that the therapies will involve my taking medications, including narcotic medications, which will help to control my chronic, intractable pain.

It has been explained to me that these medications(s) include narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these narcotic medication(s) are potentially addictive and may, like other drugs used in the practice of medicine, produce adverse affects or results. (See attached Narcotic Information Sheet.) The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) for the treatment of my chronic, intractable pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that taking narcotic(s) on a regular basis is meant to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of narcotic(s). I realize that the treatment for some people will require prolonged or continuous use of controlled medication(s) and that my condition will be evaluated on an individual basis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time, and I will be afforded detoxification under medical supervision.

I will use the medication(s) exactly as directed by the doctors and/or his appropriately authorized assistants(s).

I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) should be protected as if it were money. If either are lost or stolen, they **WILL NOT BE REPLACED** unless I file a police report and bring the doctors and/or appropriately authorized assistant(s), a copy of the report. Otherwise, I will need to wait until my next scheduled refill.

Refill(s) will not be ordered before scheduled refill date. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date, **but not on a regular basis**. Otherwise, I will not expect to receive additional medications(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

All requests for medication(s) or refill(s) must be made by the patient directly not by family members or friends.

I will receive controlled substance(s) or medication(s) **only from the doctors and/or appropriately authorized assistant(s) at The Spine Center of Southeast Georgia** unless it is for an emergency or the controlled substance(s) that are to be prescribed by another physician are approved by the doctors and/or appropriately authorized assistant(s). Information that I have been receiving medication(s) prescribed by other doctors, and the doctors and/or appropriately authorized assistant(s) have not approved of, may lead to a discontinuation of medication(s) and treatment.

Until the doctors and/or appropriately authorized assistant(s) have gotten to know me and my medical history well, I understand that prescription(s) for larger quantities medication(s) to cover me while I am out of town will not be given. Later, depending on my compliance, the doctors and/or appropriately authorized assistant(s) may modify this.

A record of my medication(s) and pain diary may be required to document my progress and compliance. These diaries must be filled out in its entirety and returned at my next scheduled visit. Failure to do so will be considered noncompliance with medical treatment.

If it appears to the doctors and/or appropriately authorized assistant(s) that there are no **demonstrable benefits to my daily function or quality of life** from controlled substance(s), then the doctors and/or appropriately authorized assistant(s) may taper me off of all narcotic(s). I will not hold the doctors and/or appropriately authorized assistant(s), and/or any other employees, or members of The Spine Center of Southeast Georgia liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substances(s), treatment for chronic pain with narcotics will be terminated.

I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program to secure increased functioning and improved coping with my condition.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic(s) and controlled substance(s) treatment program, since the use of other drug(s) in conjunction with some may cause me harm.

I also understand that during the course of treatment, certain clinical conditions or situations may make it necessary to use additional or different procedures than those explained to me. At this time, I understand that if these alternate procedures are used, the doctors and/or appropriately authorized assistant(s) will explain them to me at that time.

I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize the doctors and/or authorized assistant(s) to release my medical records to my pharmacist at his/her discretion.

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:

Pharmacy: _____ **Phone #** _____

Pharmacy Address: _____

For female patients only:

To the best of my knowledge, I am not pregnant at this time and I will use appropriate contraception during my course of treatment.

Besides the possible risks involved with the long-term use of narcotic(s) and controlled substance(s), I further understand that information on the effects of narcotic(s) and controlled substance(s) on pregnant women and their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effect(s). The medications may cause birth defects.

All of the above possible effects of narcotic(s) and controlled substance(s) have been fully explained to me and I understand that at present, there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform the doctors and/or appropriately authorized assistant(s) immediately if I become pregnant in the future.

I hereby give the doctors and/or appropriately authorized assistant(s) permission to communicate with the referring physician(s) and any Pharmacist(s) regarding my use of controlled substance(s).

I must take the narcotic medication(s) exactly as instructed by the doctors and/or appropriately authorized assistant(s) or in smaller doses. Any unauthorized **increase** in the dose of narcotic medication(s) may be viewed as a cause of discontinuation of the treatment with narcotic medication(s) or dismissal.

If I demonstrate unacceptable behavior patterns the doctors and/or appropriately authorized assistant(s) may discontinue prescribing the narcotic medication(s) for me.

I must keep all regular follow up appointments as recommended by the doctors and/or appropriately authorized assistant(s). Failure to comply may cause discontinuation of narcotic prescription(s).

I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g. alcohol and prescription drugs) which impairs my ability to drive, or operate heavy machinery is illegal and could cause harm to me or others.

I agree I will bring pill bottles or containers for controlled substances with me to each appointment/procedure with the remainder of pills.

The physician whose signature appears below or, during his/her absence, the covering physician has my permission to contact any law enforcement agency to determine if I am under investigation for narcotics related activities.

In the event you are arrested or incarcerated, refills on controlled substances will not be given.

I understand that I am solely responsible for the safekeeping of my medications.

I understand that abusive, threatening behavior or harassment toward any Spine Center of Southeast Georgia staff will not be tolerated, and may lead to dismissal from the practice.

I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from Spine Center of Southeast Georgia, and notification of the appropriate law enforcement agencies.

Prescription Refills - You must call at least **5 business days** before your medication runs out. **Our**

Medication Refill Hotline is 912-262-6552 Ext. 251

Monday-Thursday 8:00am-5:00pm Friday 8:30am-2:00pm

You must call to request the refill yourself and the staff will ask questions to establish your identity. Please do not phone for prescriptions after hours or on the weekends.

ONLY the PATIENT, unless given permission otherwise by your provider may pick up the prescription and the staff will request ID.

Evidence of medication hoarding; increasing the amount of medication without communication to the doctors and/or appropriately authorized assistant(s); refilling my prescription too frequently; getting the medication from multiple physicians; increasing the amount of medication despite significant side effects; altering prescriptions; selling, trading, or giving away medication; unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic maintenance therapy, will lead to discontinuation of narcotic treatment, and possible dismissal from the practice and notification of appropriate law enforcement agencies.

I CERTIFY AND AGREE TO THE FOLLOWING:

I am not currently abusing illicit or prescription drug(s), and I am not undergoing treatment for substance dependence or abuse.

I have never been involved in the sale, illegal possession, diversion or transport of controlled substance(s) (narcotic, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that I would otherwise continue to have chronic pain.

I agree to review medication instructions provided by the pharmacy.

I have received the information sheet reviewing the side effects of the narcotics that may be used in the treatment or my chronic pain. I fully understand the explanations regarding the benefits and the risks of this method.

I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

Patient's Signature	Review	Review	Review	Review
	Date/Initial	Date/Initial	Date/Initial	Date/Initial

Physician and/or Appropriately Authorized Assistant(s) Signature	Date
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Witness Signature	Date
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