9218 Kimmer drive, Suite 107 Lone Tree, CO 80124 Phone (303) 471-4690 Fax (303) 471-4697

New Patient Medical History - Please complete this form prior to your first appointment

Legal Name: _____ Prefer to be called: _____
Date of Birth: ___/___/___ Age: ____ Gender: ____ SSN:___ - ____ - _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____
Employed: _____ Unemployed: _____ Student: _____ Retired: _____
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our practice?

♦ Insurance Information ♦

What type of claim is this? ___Health Insurance ___ Work Comp ____Auto ____ Self-Pay
Primary Insurance Company: _____
Policy Holder's Name: _____ Date of Birth: _____/_____/_____
SSN:___ - ____ - _____ Policy Holder's Employer: _____
Member ID or Claim #:_____ Group #: _____
Effective Date or Date of Injury: _____/_____/_____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster Name: _____ Adjuster Phone: _____

Secondary Insurance Company: _____
Policy Holder's Name: _____ Date of Birth: _____/_____/_____
SSN:___ - ____ - _____ Policy Holder's Empolyer: _____
Member ID or Claim #:_____ Group #: _____
Effective Date or Date of Injury: _____/_____/_____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster Name: _____ Adjuster Phone: _____

Signature: _____ Date _____/_____/_____

Guarantor (Person responsible to pay the bill):
- o Self
- o Other: _____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Primary Care, Pain physician, Orthopedics, Psychiatry, etc)

Name of Provider: _____ Office Name: _____ Office #: _____

Name of Provider: _____ Office Name: _____ Office #: _____

♦ Referring Physician ♦

List below who referred you to our practice

Name of Provider: _____ Office Name: _____ Office #: _____

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ Depression or Anxiety			
❑ Anticoagulation			
❑ Neck/ Low Back Pain (Please circle)			

♦ Past Surgical Procedures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Do you use marijuana?	Do you use other drugs?	
Are you concerned that you may have been exposed to HIV or Hepatitis? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Headaches	Cough	Abdominal pain	Easy bruising	Excessive thirst
Vision problem/loss	Excess sputum	Diarrhea	Blood clot	Seizures / Tremor
Double vision	Bronchitis	Constipation	Joint pain / stiffness	Weakness
Hearing problems	Shortness of breath	Bowel incontinence	Other joint problem:	Numbness/tingling
Ringing in the ears	Other lung problem:	Other belly problem		Other neurologic problems:
Nasal discharge			Low back pain	
Sore throat	Chest pain	Leg swelling	Low back stiffness	
Trouble swallowing	Fast heart rate	Leg edema		Anxiety/Depression
Hoarseness	Other heart problem	Frequent Urination	Weight loss / gain	Other psychiatric conditions
Neck pain		Urinary incontinence	Heat/cold intolerance	
Neck stiffness	Nausea/ Vomiting		Excessive hunger	

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ **Disease Prevention and Health Maintenance** ♦ *Please list below the most recent dates of your vaccines and health screening tests*					
	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		EKG		Heart Stress Test	
Pneumonia Vaccine		Chest X-Ray		Heart Catheterization	
Tetanus Vaccine		Bone Density			
Hepatitis B Vaccine		Eye Exam			
Shingles Vaccine					
HIV Test					

THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ **DATE:** _____/_____/_____

ROCKY MOUNTAIN
BRAIN & SPINE
INSTITUTE

Patient Name: (Last, First): _____
Date of Birth: ____/____/_____

Consent of Medical Treatment

1) **CONSENT FOR HEALTH CARE SERVICES**. I authorize physician(s), physician assistants(s), and/ or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Rocky Mountain Brain & Spine Institute practices. This authorization includes, but is not limited to: medical services, diagnostic procedures, diagnostic imaging, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care provider(s) will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that Rocky Mountain Brain & Spine Institute may release copies of my medical records to other physicians, practitioners and healthcare providers or facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment of services rendered in/ by the practice. I acknowledge that no promises or guarantees have been made to me regarding outcome from recommendations or treatment by Rocky Mountain Brain & Spine Institute.

2) **NON-ROCKY MOUNTAIN BRAIN & SPINE INSTITUTE PROFESSIONALS/ FACILITIES**. I understand that I may receive services from professionals or facilities who provide care to me or are involved in my care/ treatment who are not employees or agents of Rocky Mountain Brain & Spine Institute. These professionals may include other physicians/providers requested by my physician to participate in my care as well as radiology, pathology, neuromonitoring technicians and neuromonitoring readers, and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from Rocky Mountain Brain & Spine Institute. **I understand that, in some cases, these non- Rocky Mountain Brain & Spine Institute professionals or facilities may not be participating providers or facilities under my insurance plan. I understand it is my responsibility to verify whether professionals/facilities providing my care are participating providers/ facilities under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.**

3) **MEDICARE AND/OR MEDICAID CERTIFICATION.** I certify that the information given to me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice of my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

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BRAIN & SPINE
INSTITUTE

Patient Name: (Last, First): _____
Date of Birth: ____/____/_____

4) **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and or physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. **I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.**

5) **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6) **ASSIGMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians/ providers. I understand that I am financially responsible to the practice or my physician/ providers for charges not covered or paid pursuant to this authorization.

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INSTITUTE

Patient Name: (Last, First): _____
Date of Birth: ____/____/_____

7) **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Rocky Mountain Brain & Spine Institute has offered me a copy of its Notice of Privacy Practices. I understand this acknowledgement in no way affects the care I shall receive at the practice.

By checking one of the circles below, I acknowledge:

- o **I have been offered or accepted a copy of the Notice of Privacy Practices**
- o **I declined a copy of the Notice of Privacy Practices**

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____ _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

_____

RELATIONSHIP/ REASON WHY PATIENT IS UNABLE TO SIGN

_____

ADDRESS OF PATIENT

ROCKY MOUNTAIN
BRAIN & SPINE
INSTITUTE

9218 Kimmer Drive
Suite 107
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P- 303-471-4690
F- 303-471-4697
Dr. Adam P. Smith, MD

Notice of Privacy Practices

Effective 4/9/2016

Your personal medical information is private

Rocky Mountain Brain & Spine Institute understands how important your personal medical information is to you. We know you are concerned with how that information might be used, the way in which it is disclosed and how you can access that information. That is why we've put this document in your hands. It's why the "Privacy Practices" outlined here are so important and why we want to pledge our commitment to respect your medical information.

Your personal medical information is private

We understand that your medical information is personal and confidential. We create a medical record of the care you receive because it's our legal obligation, but more importantly because we want to provide you with quality care. Please know we are committed to protecting your personal medical information from any use for which it wasn't intended. The law requires us to:

- Keep your medical information private.
- Notify you of our legal duties and privacy practices with respect to your medical information.
- Follow the terms of the most current notice

Adhering to privacy practices

The U.S. Department of Health and Human Services sponsored the Health Insurance Portability and Accountability Act (HIPAA). If you have any questions regarding the contents of this Notice of Privacy Practices, please contact 303-471-4690, ask for the designated privacy officer. This notice describes the Rocky Mountain Brain & Spine Institute practices and that of:

- Any health care professional who treats you at any of our locations.
- All departments of our organization.
- All employees or staff of our organization.
- Any business associate or partner with whom we share health information.

Be assured that all these individuals and organizations understand that the privacy of you medial information is important, and will be following HIPAA guidelines to ensure that your information is used only as it is intended.

How your personal medical information can be used and disclosed

The following is a list of ways in which your personal medical information can be used and disclosed as allowed under HIPAA provisions. Be assured that we will use your information in the most discreet manner.

continued>

Notice of Privacy Practices continued

Disclosure for health care related purposes

We may use and disclose your medical information for health care related purposes including:

- Treatment, such as sending your medical information to a specialist as part of a referral.
- Obtaining payment for treatment, such as sending billing information to your insurance company or Medicare/ Medicaid.
- Supporting our health care operations, such as comparing patient data to improve treatment methods.
- Communicating with business partners. These business partners are required by contract and law to comply with the provisions of HIPAA and protect your rights as well.

Disclosure to other organizations

Subject to certain requirements, we may share your medical information to other organizations without prior authorization for:

- Public health purposes
- Research studies
- Organ donation
- Emergencies
- Abuse or neglect reporting
- Funeral arrangements
- Worker's compensation purposes
- Health oversight audits or inspections

Disclosure to legal agencies

We also disclose medical information when required by law in response to:

- Requests from law enforcement agencies in specific circumstances.
- Valid judicial or administrative orders.
- The government, if you are in the military or a veteran.
- National security and intelligence agencies/ activities.
- Protective services for the President and others.

Disclosure for contact with you

We also may use your medical information for contact with you, for:

- Appointment reminders.
- Possible treatment options and alternatives.
- Health-related benefits or services that may of interest to you.

Disclosure for contact with you

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing your medical information. If you choose to authorize use or disclose information you can later revoke that authorization by notifying us in writing of you decision.

ROCKY MOUNTAIN
BRAIN & SPINE
INSTITUTE

Authorization to Disclose Information

I, _____ authorize and permit Rocky Mountain Brain & Spine Institute to disclose the following medical information: (check all that apply)

- ❑ Services rendered at this office (including participation in research studies)
- ❑ Last office visit, laboratory and/or imaging test results
- ❑ Information regarding mental illness, substance abuse, or infectious diseases
- ❑ Medications prescribed
- ❑ Scheduled appointments / telephone confirmation of appointments on answering machine
- ❑ Billing Statements / Correspondence from this office
- ❑ Email correspondence
- ❑ Other (Please Specify)

_____

_____

To the following family member or person listed below:

Name: _____ Relationship to Patient:_____Phone #_____

Name: _____ Relationship to Patient:_____Phone #_____

This authorization is effective _____ and shall continue to be effective until otherwise revoked in writing by me. If your wish to revoke this authorization, you must do so in writing to your physician at Rocky Mountain Brain & Spine Institute. If you choose to revoke this authorization, it will become effective upon receipt but will not apply to disclosures previously made with your consent.

My signature below acknowledges that a copy of the privacy practices followed at Rocky Mountain Brain & Spine Institute is available to me upon request.

Patient Name: _____ Date of Birth: _____

Signature: _____ Social Security # _____

Or Power of Attorney: _____

Rocky Mountain Brain and Spine Institute
Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments/Balances: Co-payment, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment (per your contract with the insurance). **All account balances must be paid within six (6) months of receiving your first statement. We are happy to set up a payment plan.** Payment may be made by: cash, check, or credit card. Nonpayment may result in your account being turned over to a collection agency.

Insurance Payments: We participate in assignment of payment with **specific** insurance plans in the area. It is your responsibility to ensure our providers are participating/contracted with your insurance plan. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Referrals/Authorization: It is your responsibility to obtain any referral/authorization required by your insurance carrier prior to services being rendered. Failure to obtain required referral/authorization will result in you being responsible for the full balance.

Self-Pay
Patients who are not billing a third party or health insurance are required to pay at the time of service for all office services at the time of service and will receive a 25% discount off our fee schedule. All procedures requiring services at a facility (hospital or surgery center) are pre-paid to the office at least five (5) business days prior to the procedure and will receive a 25% discount. If payment is not received within the specified time period, your procedure will need to be rescheduled.

Additional Fees:

Missed appointments: Please understand your appointment is time that has been reserved for your needs and that your lack of attendance at that visit prevents others from receiving care at that particular time. To assist patients with access to our physicians, we will charge a fee of $50.00 for any office appointment not canceled 24 hours in advance.

Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms require additional physician and staff time. A fee of $25.00 will be charged for each form completed.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non-payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice. The responsible party will be required to pay all late fees, collection fees, in addition to the balance on the account.

Bounced Checks: A $30.00 charge will be applied for each check returned by the bank or your account will be placed immediately with a third party collection agency for collection.

Your signature on this page constitutes an agreement to this policy.

I have read and agree to the above policies and authorize payment directly to Rocky Mountain Brain and Spine Institute.

Signature of Person Responsible for Account/Patient _____ **Date** _____

Printed Name _____

ROCKY MOUNTAIN
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www.rmbsi.org

Pain Management Policy

The purpose of this agreement is to give you information about the medications you will be taking for pain management and spasms following surgery. It is also to assure that you and your health care provider comply with state and federal regulations concerning the prescribing and use of controlled substances.

Opioids (narcotic analgesics) and muscle relaxants are classes of medications that are prescribed to help alleviate pain and muscle spasms. They can be very helpful in the management of postoperative symptoms.

The long-term use of opioids or muscle relaxants for pain management is controversial because of uncertainty regarding the extent to which they provide long-term benefit. Based on most information, we do not recommend long-term use of opioids or muscle relaxants.

It is important to understand some of the side effects of these medications. Opioids and/or muscle relaxants may cause drowsiness, confusion or physical impairment that can be worsened by the use of alcohol, benzodiazepines, and other sedating medications. If unsure about mixing any medication with an opioid or muscle relaxant, please ask a health care provider or pharmacist. Patients must avoid any activity that may be dangerous to their self or someone else while taking these medications. It is against the law to drive while taking opiate pain medications or muscle relaxants.

Pain medications and muscle relaxants may cause addiction. Patients addicted or tolerant to these medications may seek other illicit opiate drugs, including but not limited to heroin. Some abusers of illicit drugs, such as heroin, blame prior surgeries and postoperative medication use as the cause of their drug problem. At Rocky Mountain Brain & Spine Institute (RMBSI), we do not assume any blame or responsibility for patients not cessating medication use after surgery, or eventually pursuing/ abusing illicit drugs such as heroin.

Any prescription for opioids or muscle relaxants by RMBSI will strictly be for acute postoperative symptoms, of short duration, and not to exceed three (3) months. We do not provide any pain management prior to surgery. If the patient is unable to follow the agreed upon schedule or requires more than three (3) months of prescription medications, he or she must contact their primary care physician or seek a pain management specialist for continued pain management. RMBSI is not a general pain management provider. We are not obligated to help you find a pain management specialist.

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RMBSI will immediately stop prescribing any pain medication or muscle relaxant if we discover a patient is not taking these medications as prescribed, or the patient is obtaining similar medications from another provider without our knowledge. We frequently follow online databases, which report opiate and muscle relaxant usage by our patients.

Patients entering the practice while currently on a maintenance course of prescribed opioids or muscle relaxants for chronic pain will need to obtain their maintenance prescription medications from the original prescriber.

We prescribe "standard doses" of pain medications and muscle relaxants following surgery regardless of how much a patient is taking before surgery. It should not be expected that RMBSI will increase or maintain elevated medication dosages following surgery to meet the elevated needs of certain patients.

Physical dependence may develop with regular use. This does not necessarily indicate addiction but means that a physical withdrawal syndrome may develop if you stop your medication abruptly. Tolerance may develop to the pain-relieving effects of opioids or muscle relaxants, meaning that pain relief may decrease over time. If long-term medications were taken prior to surgery, patients should expect to have significant pain following surgery that may be difficult to control. This does not mean the surgery did not work.

Some pain conditions, including post-operative pain, may not improve with opioids or muscle relaxants. A frequent need to increase doses may indicate that these medications are not effective for a particular pain problem. It could also indicate an underlying problem with addiction or psychological dependence. Discontinuation of opioid or muscle relaxant medications may occur if pain relief is not adequate in spite of escalating doses, persistent side effects, if goals of opioid therapy are not being met, or there is inability to comply with the treatment agreement.

It is important to understand that a patient can overdose from a pain medication or muscle relaxant, even if they are still having pain or spasms.

Opioid medications and muscle relaxants have potential for abuse or diversion and strict accountability is necessary. For this reason the following policies are agreed to by you:

1. Pain medication and muscle relaxants will be prescribed only in written form. They will not be phone called or faxed to a pharmacy. They will not be electronically submitted. They will only be provided in person to the actual patient, and only during normal business hours Monday through Friday. If a prescription is needed, it is recommended you call ahead to make sure the

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doctor is present to write the prescription. You alone are responsible for knowing if your medications are running low. If you call the RMBSI answering service outside of normal business hours, you will be advised to wait until normal business hours or go to an urgent care/ emergency room to obtain medications.

2. All prescriptions must be taken as prescribed. Taking the medications differently could be dangerous and even cause death. We may not refill a prescription early, even if another healthcare provider told you to take the medication differently than we prescribed.

3. Your pharmacist, at their discretion, may provide a lesser amount of medication than we prescribe. We will not intervene in this decision. Many Colorado pharmacies only will fill one week of medication, even if we wrote for a 2-week supply.

4. We have permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. We have permission to check online databases reporting the patient's pain medication and muscle relaxant use. However, we are not obligated to check these databases for the purpose of predicting elevated medication need or baseline medication tolerance.

6. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

7. Stopping opioids abruptly can cause flu-like withdrawal symptoms such as nausea, vomiting, diarrhea, and sweating. While not always dangerous, this can be very uncomfortable. It is best to wean from opioids.

8. You cannot share, sell, or otherwise permit others to have access to your medications. This includes a spouse, significant other, or family member.

9. Prescriptions and medication bottles may be sought by other individuals and should be closely safeguarded. Since the drugs may be hazardous or lethal to a person, especially a child, you must keep them out of reach of such people. It is expected that you will take the highest possible degree of care with your medication and prescription. It is best to lock up your medication in a safe or lock box. You should not leave your medications where others might see or have access to them.

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10. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, have been stolen, etc… It is your responsibility to keep your medications safe.

11. Refilling medications are contingent on keeping scheduled appointments. If you miss or cancel your appointment, we may not refill your medications.

12. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit. If it appears you are not receiving the intended benefit, we may stop prescribing the medications.

13. It is understood that failure to adhere to these policies may result in cessation of prescribing pain medications or muscle relaxants.

14. 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 terms.

Patient Signature: _____

Printed Name: _____

Date: _____