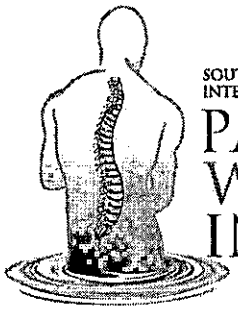


SOUTH FLORIDA
INTERVENTIONAL
PAIN&
WELLNESS
INSTITUTE

Dear Valued Patient,

Thank you for choosing the South Florida Interventional Pain & Wellness Institute.

We are dedicated to offering the finest possible care to your health. In order to ensure the highest quality of care, please take a few moments to complete our New Patient Packet enclosed. Please bring this in to your first visit with us, along with your health insurance card, photo ID, radiological studies, etc. We realize that health insurance is complex, so we can provide full assistance to you if you have any questions.

Thank you, and we look forward to meeting you.

Sincerely,

Dr Davis, Dr. Daly, & Our Team at the Pain & Wellness Institute

South Florida Interventional Pain & Wellness Institute
1951 SW 172 ave
suite 314
Miramar, FL 33029
phone-954.447.5206
fax-954.446.5259

www.FloridaPainCenter.com
www.Facebook.com/FloridaPainCenter
www.Twitter/SoFloPain

PATIENT INFORMATION FORM

PATIENT CHART # _____ DOCTOR/MIDWIFE _____

PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX# _____

NAME _____ SEX ☐ M ☐ F

SOCIAL SECURITY # _____ BIRTHDATE _____ MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

RELIGION _____ AGE _____ HOME PH. # ( ) _____ CELL PH. # ( ) _____

STREET ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

DRIVER'S LICENSE # _____ DRIVER'S LICENSE STATE _____

EMPLOYER/SCHOOL _____ TITLE _____ PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE _____ AGE _____ BIRTHDATE _____

SPOUSE EMPLOYER _____ TITLE _____ PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

TRANSLATOR NEEDED ☐ YES ☐ NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY: _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME _____

EMPLOYED BY _____

POSITION _____

PHONE _____

MOTHER'S NAME _____

EMPLOYED BY _____

POSITION _____

PHONE _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE # _____

I.D. # _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC. # _____

INSURED'S D.O.B _____

RELATIONSHIP TO INSURED _____

(Self— Husband— Wife— Child— Other)

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE # _____

I.D. # _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC. # _____

INSURED'S D.O.B _____

RELATIONSHIP TO INSURED _____

(Self— Husband— Wife— Child— Other)

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature _____ Date _____

(Patient's parent, if minor)

Authorization to Discuss Protected Health Information*

I, _____, authorize _____

_____

to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**:

1. _____ 3. _____

2. _____ 4. _____

_____

➢ *PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

➢ **YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

_____

Please list phone numbers where you would like us to contact you for:

- Results - lab, X-ray, Ultrasounds, Mammograms, etc.
- Reminder notices
- Changes on scheduled appointments

1. _____

2. _____

_____

Patient's name: _____

DOB: _____

SS#: _____

Date: _____

Patient's Signature: _____

++

ADVANCE DIRECTIVE

DO YOU HAVE AN ADVANCE DIRECTIVE/LIVING WILL? _____ IF YES, PLEASE PROVIDE US WITH A COPY FOR OUR RECORDS.

IF NO, PLEASE LET US KNOW IF YOU REQUIRE INFORMATION.

I hereby authorize the use of and/or disclosures of any telephone number, provided by me or on my behalf, that is assigned to a residential line, cellular telephone service, paging service, facsimile machine, computer, or any other service or device for which the called party is charged for the call for the purpose of billing and collecting payment for medical services rendered to me. This consent applies to any call made using an automatic telephone dialing system or an artificial or prerecorded voice.

South Florida Interventional Pain & Wellness Institute
Dr. Lowell Davis & Dr. Rosemary Daly

Name: _____ Date: _____ DOB: _____

Occupation: _____ Problem began when: _____

Type of Injury: ☐ at work/work related ☐ at home ☐ slip/fall ☐ MVA ☐ sports injury ☐ arthritis

Have you been unable to work due to your injury? ☐ Yes ☐ No How long? _____

Have you been seen in an Emergency Room? ☐ Yes ☐ No Name of Hospital? _____

Have you had an MRI of the injured area? ☐ Yes ☐ No Name of Facility? _____

Present Pain History

Back Pain	Neck Pain	Pain Level at worst
☐ Back pain only; no leg pain	☐ Neck pain only; no arm pain	0-1-2-3-4-5-6-7-8-9-10
☐ Back pain worse than leg pain	☐ Neck pain worse than arm pain	0-1-2-3-4-5-6-7-8-9-10
☐ Back and leg pain are equal	☐ Neck and arm pain is equal	0-1-2-3-4-5-6-7-8-9-10
☐ Leg pain worse than back pain	☐ Arm pain worse than Neck pain	0-1-2-3-4-5-6-7-8-9-10
☐ Leg pain only; no back pain	☐ Arm pain only; no neck pain	0-1-2-3-4-5-6-7-8-9-10

Do you have any of the following symptoms? ☐ Numbness ☐ Tingling ☐ Pins and Needles
Treatments for your current pain include: ☐ Medication ☐ Physical Therapy ☐ Chiropractor
☐ Injections ☐ acupuncture ☐ Massage ☐ Cold/Hot Packs ☐ Exercise/Stretching ☐ TENS Unit

Medical History

Disease	When Diagnosed	Treatments	Disease	When Diagnosed	Treatments
High Blood Pressure			Bleeding Disorder		
Heart Problems			Incontinence(Bowl/Bladder)		
Seizures			Nerve Disease		
Diabetes			Kidney Problems		
Asthma			Liver Problems		
Cancer			Stroke		
Chemo/Radiation			High Cholesterol		
Emphysema			Hepatitis		
Thyroid Problems			Osteoporosis		
Ulcers			Arthritis		
Migraines			Lung Disease		
HIV/AIDS			Nausea/Vomiting		
GI Problems			Other:		

Are you allergic to any medications? ☐NO ☐YES If yes, please list:

_____

Are you taking any anticoagulants (blood thinners)? ☐NO ☐YES If yes, please list:

_____

In the past 6 months to a year, what tests have you had to evaluate your pain? _____

_____

South Florida Interventional Pain & Wellness Institute
Dr. Lowell Davis & Dr. Rosemary Daly

Do you drink caffeinated drinks? ☐NO ☐YES Cups per day _____ (Coffee, Teas, Cola, etc)

Do you drink Alcoholic beverages? ☐NO ☐YES Drinks per day? _____

Do you smoke cigarettes or cigars? (yes if within 1 year) ☐NO ☐YES

If yes please specify: Packs per day: _____ Cigars per day: _____

Did you ever use street drugs? (yes if within 1 year) ☐NO ☐YES If yes, please specify:

Marijuana Cocaine Amphetamines Other: _____

Please list ALL current medications that you are taking:

Medications:	Reason:	Dose:	How long used?

What medications have you taken in the past for pain?

☐ Avinza	☐ Darvocet	☐ Darvon	☐ Duragesic	☐ Hydrocodone		
☐ Kadian	☐ Lorcet					
☐ Lortab	☐ Methadone	☐ Morphine	☐ MS Contin	☐ Norco	☐ Oromorph	☐ Oxycodone
☐ Oxycontin	☐ Percocet	☐ Percodan	☐ Talwin	☐ Tylenol#3	☐ Tylenol#4	☐ Tylox
☐ Ultracet	☐ Ultram	☐ Advil	☐ Aleve	☐ Arthrotec	☐ Bextra	☐ Celebrex
☐ Mobic	☐ Motrin	☐ Naprosyn	☐ Naproxen	☐ Flovicet	☐ Florinal	☐ Gabapentin
☐ Gabitrel	☐ Lamictal	☐ Neurontin	☐ Topamax	☐ Baclofen	☐ Fexeril	☐ Methcarbamol
☐ Norflex	☐ Paraton Forte		☐ Robaxin	☐ Skelaxin	☐ Soma	☐ Zanaflex

Other: _____

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

_____ _____
Patient's Signature Date

_____ _____
Physician's Signature Date

South Florida Interventional Pain & Wellness Institute

Dr. Lowell Davis & Dr. Rosemary Daly

Have you experienced any of the following in the past 6 months:

(Please answer ALL questions)

Constitutional		
Fever	YES	NO
Chills	YES	NO
Sweats	YES	NO
Anorexia	YES	NO
Recent Weight Changes	YES	NO
Eyes		
Blurred Vision	YES	NO
Double Vision	YES	NO
Eye Irritation	YES	NO
Vision Loss	YES	NO
Eye Pain	YES	NO
Photosensitivity	YES	NO
ENT		
Ear Pain	YES	NO
Ringing in the Ears	YES	NO
Decreased Hearing	YES	NO
Nosebleeds	YES	NO
Sore Throat	YES	NO
Horseness	YES	NO
Voice Change	YES	NO
Cardiovascular		
Chest Pain	YES	NO
Heart Beat Changes	YES	NO
Fainting Episodes	YES	NO
Shortness of Breathe	YES	NO
Respiratory		
Cough	YES	NO
Spitting up Blood	YES	NO
Asthma/Wheezing	YES	NO
Gastrointestinal		
Nausea/Vomiting	YES	NO
Frequent Diarrhea	YES	NO
Constipation	YES	NO

Genitourinary		
Painful Urination	YES	NO
Frequent Urination	YES	NO
Blood in Urine	YES	NO
Musculoskelatal		
Difficulty in Walking	YES	NO
Joint Pain	YES	NO
Joint Stiffness or Swelling	YES	NO
Weakness of Muscle	YES	NO
Weakness of Joint	YES	NO
Numbness or Tingling	YES	NO
Cold Extremities	YES	NO
Neurologic		
Paralysis	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Tremors	YES	NO
Balance Problems	YES	NO
Headaches	YES	NO
Psychiatric		
Depression	YES	NO
Anxiety	YES	NO
Memory Loss	YES	NO
Mental Disturbances	YES	NO
Suicidal Ideations	YES	NO
Endocrinologic		
Heat Intolerance	YES	NO
Cold Intolerance	YES	NO
Excessive Thirst	YES	NO
Excessive Hunger	YES	NO
Excessive Urination	YES	NO
Hematologic		
Easily Bruise/Bleed	YES	NO
Hives	YES	NO
Enlarged Lymph nodes	YES	NO
Hives	YES	NO
Hay Fever	YES	NO
Persistent Infections	YES	NO

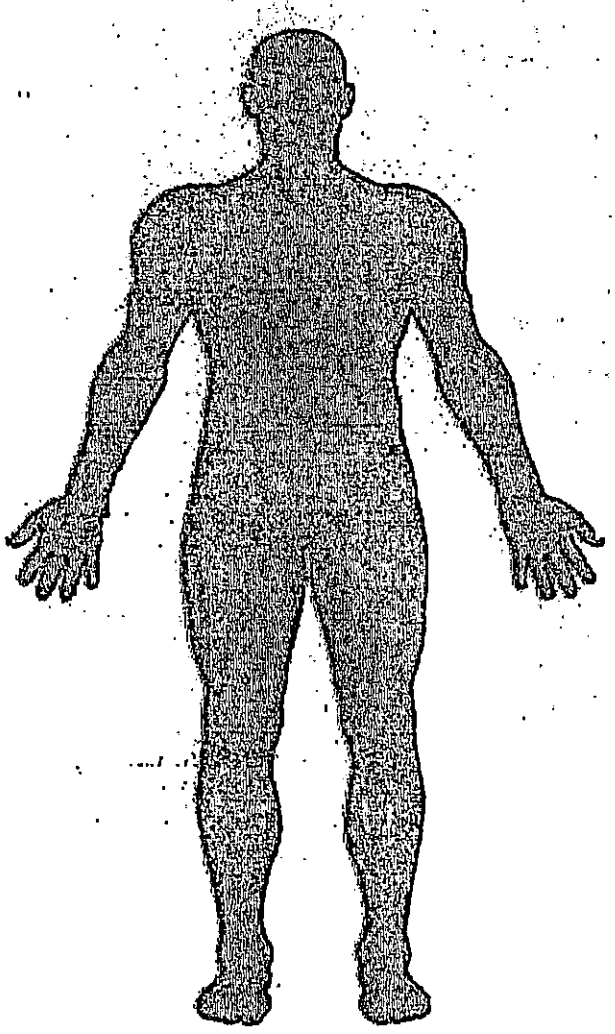
Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

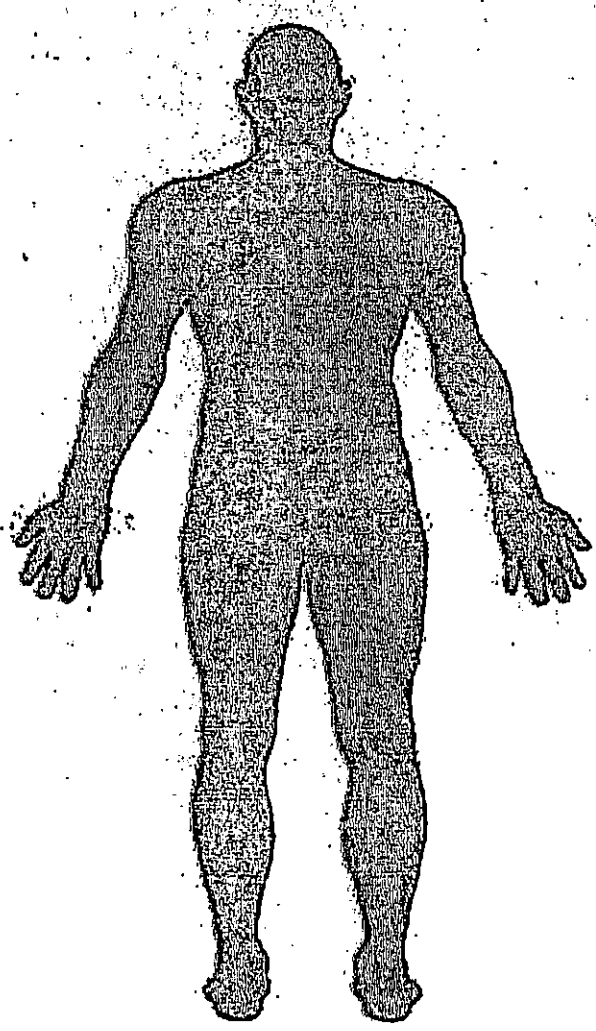
NAME : _____

INTERVENTIONAL PAIN & WELLNESS INSTITUTE

Please draw an "X" to indicate where your pain is located



FRONT



BACK

Interventional Rehabilitation of South Florida d/b/a International Pain Physicians of Miramar

Authorization for Release of Medical Information

Patient Name: _____ **Date of Birth:** _____
Address: _____
Phone #: _____ **Social Security #:** _____
I authorize _____
_____
to release any and all medical information relating to my treatment from _____ to _____.
This is to include all records, if any, concerning HIV or AIDS, mental or behavioral health or psychiatric care, and drug or alcohol abuse.

Purpose of this request: For provision of continuing medical care

Specific items to be released:

__ Cardiovascular Reports __ Emergency Room __Pathology Reports
__ Consultation Reports __ History & Physical __ Progress Note
__ Discharge Summary __ Laboratory Results __ X-Ray Reports
__ EKG Reports __ Operative Reports
__ Photographs, videotapes, or other digital images X Records of prescription medications
Other (describe) _____

Send Information via __Mail __Fax to: or __ Hold for pick-up by authorized Representative of:

Dr. Lowell Davis/ Dr. Rosemary Daly
1951 SW 172nd Avenue, Suite #314
Miramar, FL 33029
Telephone # (954) 447-5206 Fax# (954) 447-5259

I understand that this consent can be revoked at any time except to the extent that action has been taken prior to revocation. If not previously revoked, this consent will terminate one year after the date of my signing this consent.

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Printed Name of Patient or Legal Guardian **Relationship to Patient**

Interventional Pain Physicians of Miramar
Patient Referral Sheet

Patient Name: _____

Who referred you to our practice? _____

How did hear about us? (Please check off all that apply)

_____ Referral from a family member/friend (Name: _____)

_____ Insurance Plan, Plan Directory Listing and/or Plan Website

_____ Yellow pages

_____ Television advertising

_____ Newspaper Ad (Which newspaper?) _____

_____ Radio (Which Station?) _____

_____ Seminar or Lecture

_____ Other (Please explain: _____

Date of service: _____

Physicians: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the company and its subsidiaries and affiliates. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: _____ Date: _____
(print name)

Patient Signature: _____

or

Patient's Representative: _____ Date: _____

Relationship to Patient: _____

PAIN MANAGEMENT AGREEMENT

Our goal in the field of Pain Management Medicine is to assist patients with the treatment of their chronic pain. We achieve this goal through various modalities, including injections or nerve blocks, physical therapy, exercise programs, psychological counseling when needed, and referrals to surgeons or other specialists as required. We strive to manage pain through means other than the medications to allow patients to live a relatively pain free life. We seek to treat the cause of the pain and not the symptoms. **However, we also understand that strong narcotic analgesic and other prescription medications may be indicated for the treatment of certain chronic pain conditions.**

The purpose of this agreement is to clarify the conditions under which the pain management doctor will prescribe medications to you. This agreement will help you and your doctor comply with the laws regarding controlled pharmaceutical and prevent misunderstandings about the medicines you may take for your pain condition. **Please read each and every item in this agreement very carefully.**

I UNDERSTAND AND AGREE TO THE FOLLOWING TERMS OF ANY AND ALL PRESCRIPTIONS:

1. I WILL USE MY MEDICATION(S) AT A RATE NO GREATER THAN THAT PRESCRIBED BY MY PAIN MANAGEMENT PHYSICIAN. IF I DO OVER-USE MY MEDICATION, THAT MEDICATION WILL NOT BE REFILLED EARLY, AND I MAY BE WITHOUT PAIN MEDICATION FOR SOME PERIOD OF TIME.

2. I WILL NOT SHARE, SELL, OR TRADE MY MEDICATION WITH ANYONE. I WILL NOT ATTEMPT TO OBTAIN ANY CONTROLLED MEDICINES, INCLUDING OPIOID PAIN MEDICINES, CONTROLLED STIMULANTS, OR ANTI-ANXIETY MEDICINES FROM ANY OTHER DOCTOR. I WILL SAFEGUARD MY WRITTEN PRESCRIPTIONS AND PAIN MEDICINE FROM LOSS OR THEFT. I UNDERSTAND THAT LOST OR STOLEN WRITTEN PRESCRIPTIONS OR MEDICINES WILL NOT BE REPLACED.

3. SUDDEN DISCONTINUATION OF A NARCOTIC PAIN MEDICATION MAY LEAD TO UNPLEASANT OR DANGEROUS WITHDRAWAL SYMPTOMS.

4. IN THE EVENT THAT MY PHYSICIAN FEELS THAT MY DOSE OF PAIN MEDIATION IS EXCESSIVE OR MAKES THE DIAGNOSIS OF ADDICTION, HE/SHE WILL REDUCE THE MEDICINE OVER A PERIOD TIME (DAYS, WEEKS, MONTHS) AS NECESSARY TO AVOID WITHDRAWAL SYMPTOMS. ALSO, A DRUG-DEPENDENCE TREATMENT OR DETOXIFICATION PROGRAM MAY BE RECOMMENDED.

5. I UNDERSTAND AND AGREE THAT I AM NOT TO RECEIVE ANY TYPE OF PRESCRIPTION PAIN MEDICATION OR SEDATIVE MEDICATION FROM ANY PHYSICIAN OTHER THAN MY PAIN MANAGEMENT PHYSICIAN UNLESS THERE IS A SPECIFIC MEDICAL NECESSITY. SHOULD MY CAREGIVER OR I RECEIVE ANY PAIN OR SEDATIVE MEDICATIONS FROM ANY OTHER PHYSICIAN, MY CAREGIVER OR I MUST INFORM THE PAIN CENTER EITHER BY TELEPHONE OR IN WRITING WITHIN 72 HOURS OF HAVING FILLED THE PRESCRIPTIONS.

6. REFILLS OF MY PRESCRIPTIONS WILL BE ISSUED ONLY DURING REGULAR OFFICE HOURS.

7. REFILLS WILL NOT BE AVAILABLE DURING EVENINGS, ON WEEKENDS, OR HOLIDAYS, AND WITHOUT **AT LEAST 72 HOURS NOTICE** TO MY PHYSICIAN OR HIS/HER OFFICE STAFF.

8. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP TRACK OF MY SUPPLY OF PAIN MEDICATION.

9. MY DOCTOR MAY, AT HIS/HER DISCRETION. ISSUE A REFILL OF MY MEDICATION(S) BASED ON A TELEPHONE CONVERSATION THAT WE HAVE REGARDING MY PAIN CONDITION AND THE EFFECTS THAT PRESCRIBED MEDICATIONS HAVE ON THIS CONDITION.

10. I WILL COMMUNICATE FULLY AND TRUTHFULLY WITH MY DOCTOR ABOUT THE CHARACTER AND INTENSITY OF MY PAIN, THE EFFECT OF THE PAIN ON MY DAILY LIFE, AND HOW WELL THE MEDICINE IS HELPING TO RELIEVE THE PAIN. I UNDERSTAND THAT I, OR MY CAREGIVER IS RESPONSIBLE FOR INFORMING THE PHYSICIAN EITHER IN PERSON, AT FOLLOW-UP, OR BY TELEPHONE AT THE PAIN CENTER TELEPHONE NUMBER (954-447-5206) DURING REGULAR BUSINESS HOURS REGARDING ANY PROBLEMS OR SIDE EFFECTS ENCOUNTERED WITH THE MEDICATION.

11. I HAVE BEEN ADVISED TO ABSTAIN FROM OR SIGNIFICANTLY MODERATE MY USE OF **ALCOHOLIC BEVERAGES** WHILE TAKING MEDICATION FOR MY PAIN CONDITION. I WILL NOT USE ANY ILLEGAL OR CONTROLLED SUBSTANCES, INCLUDING BUT NOT LIMITED TO MARIJUANA, COCAINE, HEROIN, ECSTASY, GHB, ETC. IF I AM A **CIGARETTE SMOKER**, I UNDERSTAND THAT I WILL BE ASKED TO QUIT. CIGARETTE SMOKERS TYPICALLY HAVE A DECREASED RESPONSE TO PAIN TREATMENT BECAUSE OF THE EFFECTS OF SMOKING ON OXYGEN DELIVERY TO PERIPHERAL TISSUES. ADDITIONALLY, **OBESITY** IS ONE OF THE MOST IMPORTANT CAUSES FOR FAILED TREATMENT FOR CHRONIC PAIN. EVERY TEN POUNDS OF EXCESS WEIGHT THAT ONE CARRIES ON HIS/HER BODY RESULTS IN ONE HUNDRED POUNDS OF INCREASED PRESSURE ON THE SPINE, VERTEBRAL DISCS, AND SPINAL NERVES. EXCESSIVE WEIGHT WILL THEREFORE RESULT IN AN INCREASE IN PAIN. IF YOU ARE OVERWEIGHT YOU WILL NEED TO ENROLL IN A WEIGHT LOSS PROGRAM. PHYSICAL THERAPY WILL ALSO BE DIRECTED TO THIS AREA AS WELL.

12. IF PHYSICAL THERAPY IS PRESCRIBED, I AGREE TO ATTEND AND PARTICIPATE TO THE FULLEST EXTENT POSSIBLE. IF THERE ARE ANY PROBLEMS WITH MY PHYSICAL THERAPY, I AGREE TO COMMUNICATE THIS TO MY PHYSICIAN SO THAT HE OR SHE CAN MAKE THE APPROPRIATE CHANGES IN MY THERAPY PROGRAM.

13. I AGREE THAT I WILL SUBMIT TO A BLOOD OR URINE TEST IF REQUESTED BY MY DOCTOR TO DETERMINE MY COMPLIANCE WITH MY REGIMEN OF PAIN MEDICATION.

14. IF REQUESTED, I WILL BRING ALL UNUSED PAIN MEDICINE TO AN OFFICE VISIT FOR A "PILL COUNT." MY PHYSICIAN MAY REQUEST ADDITIONAL "PILL COUNTS" AT ANY TIME, AND I AGREE TO COMPLY WITH THESE REQUESTS. I AGREE THAT I WILL BRING THE MOST RECENT PRESCRIPTION CONTAINER FOR EACH MEDICATION TO EACH VISIT WITH MY PHYSICIAN. THESE CONTAINERS MUST CORRESPOND TO THE LAST PRESCRIPTION RECORDED IN THE MEDICAL RECORD WITH THE PRESCRIPTION LABELS INTACT AND LEGIBLE SO THAT THE PHYSICIAN IN THE MEDICAL RECORD MAY

DOCUMENT APPROPRIATE CONTROL INFORMATION. SPECIFICALLY, THE PRESCRIPTION REGISTRATION NUMBER AND PHARMACY TELEPHONE NUMBER WILL BE NOTED AND VERIFIED.

15.I FURTHER UNDERSTAND THAT THIS AGREEMENT IS ESSENTIAL TO THE TRUST AND CONFIDENCE NECESSARY IN A DOCTOR-PATIENT RELATIONSHIP AND THAT MY DOCTOR UNDERTAKES TO TREAT ME BASED ON THIS AGREEMENT. I UNDERSTAND THAT IF I BREAK THIS AGREEMENT OR PROVIDE ANY FALSE INFORMATION, MY DOCTOR WILL STOP PRESCRIBING THESE PAIN-CONTROL MEDICINES AND I MAY BE IMMEDIATELY REMOVED FROM THE DOCTORS CARE.

I have reviewed all of the items contained in this three (3) page agreement. I agree to follow all of the guidelines that are described above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me upon request. I voluntarily consent to participation in the pain medication program described in this Agreement.

Patient Signature:_____ Date:_____

(If applicable) Legal Guardian Name:_____ Legal Guardian Signature_____

Witness Name:_____ Witness Signature:_____