REHAB AND PAIN MANAGEMENT SERVICES
PATIENT REGISTRATION FORM

TODAY'S DATE: _____ APPOINTMENT DATE & ARRIVAL TIME: _____

LAST NAME: _____ FIRST: _____

SSN: ____/____/____ DOB: ____/____/____ GENDER: MALE / FEMALE STATUS: Single – Married – Divorced

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

EMPLOYER: _____

ADDRESS: _____ WORK PHONE: _____

SECONDARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ TELEPHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ TELEPHONE: _____

WORKERS' COMPENSATION OR AUTO ACCIDENT INSURANCE INFORMATION

WORKERS COMPENSATION ____ AUTO ACCIDENT ____ STATE INJURY OCCURED ____ DATE OF INJURY: _____

EMPLOYER'S NAME AND ADDRESS: _____

INSURANCE CARRIER: _____ CLAIM NUMBER: _____

CLAIMS ADDRESS: _____

ACCEPTED CONDITIONS: _____

ADDITIONAL NOTES: _____

ADJUSTOR: _____ CASE MANAGER: _____

PHONE: _____ PHONE: _____

FAX: _____ FAX: _____

EMAIL: _____ EMAIL: _____

ADDRESS: _____ ADDRESS: _____

PATIENT'S ATTORNEY:

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ TELEPHONE: ( ) _____

HOW DID YOU FIND OUT ABOUT US?

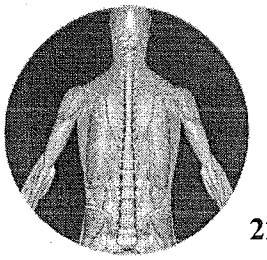
WHO SCHEDULED APPOINTMENT? _____

HOW DID THEY FIND OUT ABOUT US? _____ GOOGLE / WEBSITE ____ PHONE BOOK ____

HAVE YOU ATTENDED ONE OF DR SCHULTZ'S WORK COMP CEU WEBINARS? _____ ARE YOU INTERESTED IN A CEU? _____

HAVE YOU EVER RECEIVED ANY CALLS ABOUT OUR PRACTICE? _____

OFFICE USE ONLY: PATIENT FORMS SENT DATE: _____ AUTH REQUESTED DATE: _____



Rehab & Pain Management Services, P.A.
Neil R. Schultz, M.D.
Board Certified in Physical Medicine & Rehabilitation

1630 Medical Lane, Suite B - Fort Myers, FL 33907
2229 N Commerce Parkway, 2nd Floor Suite C – Weston, FL 33326
Phone (239) 278-5700 - Fax (239) 278-5786

ASSIGNMENT OF BENEFITS AND MEDICAL RECORDS RELEASE

I _____, hereinafter ASSIGNOR, herby authorize _____
(Name of insured patient) (Name of Insurance Carrier)

to pay directly to Rehab & Pain Management Services, P.A hereinafter ASSIGNEE, the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida statues for any service and or charge provided by ASSIGNEE. This ASSIGNMENT OF BENEFITS is given in exchange for ASSIGNEE agreeing to await payment from the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This ASSIGNMENT OF BENEFITS IS IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties. I am responsible for payment(s) of all services rendered not covered by insurance.

I _____, hereinafter ASSIGNOR, hereby authorize _____
(Name of insured patient) (Name of Insurance Carrier)

to release benefits and pay out report directly to Rehab & Pain Management Services, P.A

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) UNDER HIPAA

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of same to Rehab & Pain Management Services, P.A. hereinafter ASSIGNEE, or to any insurer providing coverage to me in connection with the processing of any claims for benefits made by me or by the ASSIGNEE herein. A photocopy of this document shall be as binding as an original signature page. I understand this authorization includes release of all psychiatric and/or alcohol/drug abuse information that may be contained in my medical records which may be protected from disclosure by state and/or federal law. I further agree to the transmittal of all such protected health information (medical records) via fax, hard copy, telephone, mail delivery, or email.

This release and authorization shall remain in effect until I provide written revocation of such release and authorization. I understand that I can revoke this release and authorization at any time in writing.

IN WITNESS WHEREOF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands,

this _____day of_____, 20____

_____ DOB _____ Last four of SS# _____
Patient's Name (Please Print Clearly)

_____ _____
Patient's signature (ASSIGNOR) Authorized Representative of ASSIGNEE

HIPAA NOTICE OF PRIVACY PRACTICES

Rehab and Pain Management Services, P.A.
1630 Medical Lane, Suite B Fort Myers, FL 33907
2229 N Commerce Pkwy, 2nd Floor Suite C – Weston, FL 33326
(239) 278-5700

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, and Inmates. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another Health Care Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

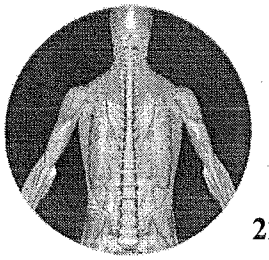
Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (239) 278-5700.

Print Name: _____ Signature: _____ Date: _____



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CONSENT TO DISCLOSE MEDICAL INFORMATION
HIPAA RELEASE FORM

Please check one of the following options:

_____ I give my permission to the employees of Rehab and Pain Management Services to disclose my protected health information to the follow individuals:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

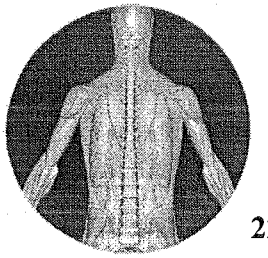
NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OR

_____ I request that all of my protected health information be disclosed only to me and no other individuals.

_____ _____
Patient or Legal Representation Signature Date



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Dear Patient

Your doctor has elected to prescribe a trial of controlled medication to treat your pain. Your doctor must follow federal and state laws and standards of care in the medical community when prescribing pain medication.

In Florida, doctors generally use a treatment agreement with any patient who receives controlled medications for chronic pain management. In fact, Florida law requires doctors to use a treatment agreement if a patient has a history of substance abuse or addiction. Your doctor has decided to use a treatment agreement with every patient in this practice who receives a prescription for a controlled medication.

A treatment agreement defines appropriate and inappropriate behavior relating to your use of controlled medication, and the consequences of failing to keep promises made under the agreement. ***It is your responsibility to review this document and tell us if you have any questions.***

Trust is important between you and your doctor. It is important to understand and follow the terms of this treatment agreement, so your doctor can advocate for your continued use of controlled medication for pain management. Thus, it is important for you to be honest with your doctor and to keep the promises you make to us in this agreement. If you fail to do so, your doctor may decide that it is best and safest to stop prescribing controlled medications to you and may even recommend that you seek care elsewhere, depending on the individual circumstances in your case. The specific terms of your treatment agreement, and consequences for your failure to follow it are set forth below.

Specific Terms Of The Treatment Agreement

As a condition of being treated with controlled medications in this practice, I, _____, promise:
(Patient Name)

1. ACCURATE AND COMPLETE HISTORY/MEDICAL INFORMATION: I will tell my doctor about all of the medication I use (prescribed, over the counter) and provide truthful information about my general medical and pain-specific history. I will tell my doctor if I have a history of substance abuse (alcohol, marijuana, other illegal substances). I will be honest with my doctor about the medications I have tried for pain management and whether these medications helped me control my pain.

2. SINGLE DOCTOR-PRESCRIBER OF CONTROLLED MEDICATIONS: I will only obtain controlled medications from **Neil R. Schultz, MD.** I understand that my doctor will periodically check my compliance by using the state's prescription drug monitoring database or individual pharmacy profile.

3. SINGLE, DESIGNATED PHARMACY: I will use only one pharmacy to fill my prescriptions for controlled medications. I have selected _____ to be my pharmacy. I understand that I must receive my doctor's approval prior to switching pharmacies. I understand my doctor may use the state's prescription drug monitoring database or individual pharmacy profile to determine my compliance with this provision.

4. SAFE USE OF PAIN MEDICATION: I will take my medication only as prescribed by my doctor and I will not increase or decrease my use (dose or frequency of dosing) of pain medication without first speaking to my doctor to obtain approval for any changes in the way I take my medication. I understand that if I do not keep this promise, my doctor may decide that it is too risky to continue prescribing controlled medications to me.

5. SAFE STORAGE: I will store my prescriptions in a safe place. I will also store my medication in a safe place, such as a safe or locking cabinet, and not give anyone access to my medications unless otherwise required by my doctor. I understand that if I am careless and lose my prescription form(s) or medication, my doctor may decide that it is too risky to continue prescribing controlled medications to me. Rehab & Pain Management Services P.A. is not responsible for any lost or stolen goods in the waiting room, exam rooms, patient accessible bathrooms, or anywhere in the facility.

6. NO SHARING/SELLING/TRADING: I will not share, sell or trade my medication with anyone, including family members or friends. I understand that if I am careless with my medication and lose it, come up short, report it stolen, or anything similar, my doctor may decide that it is too risky to continue prescribing controlled medications to me.

7. MEDICATION COUNTS: I will bring my medication with me to each office visit (stored safely and in a manner such that others cannot see what I am carrying with me) with the understanding that my doctor may count it to determine my compliance with prescription instructions. I will not do anything in attempt to mislead my doctor about the number of dosage units remaining for each of my controlled substance prescriptions.

8. AVOID ALCOHOL AND ILLEGAL DRUGS: I will avoid the use of alcohol and illegal drugs. I understand that if my doctor learns that I am using alcohol or illegal drugs that he/she may decide that it is too risky to continue prescribing controlled medications to me.

9. DRIVING RESPONSIBILITIES: I understand that it is my responsibility to contact the State's Department of Transportation (or similar agency) to learn about my legal responsibilities as a licensed driver and the State's rules regarding "drugged driving." I also understand that it is not a good idea to operate a motor vehicle (or heavy machinery) until I understand how my medication will affect me, and that I should not drive if at any time I am uncertain about my ability to make important decisions, react to traffic situations, or otherwise safely operate a motor vehicle/heavy machinery.

10. DRUG TESTING: I will provide a urine, blood, or oral fluid (saliva) sample if my doctor (or his/her staff) asks me to do so, and I understand that my sample will be tested for the purpose of determining my compliance with my pain treatment plan and this agreement, including whether:
(a) I am taking the medication prescribed to me,
(b) I am using controlled medications that have not been prescribed or otherwise authorized by my doctor under this treatment plan, and
(c) I am using illegal drugs.

If the results of my drug screen/test are inconsistent with my treatment plan or show that I am using illegal or otherwise unauthorized controlled medications, I understand my doctor may decide that it is too risky to continue prescribing controlled medications to me or treatment me in his/her practice.

11. DUTY TO KEEP APPOINTMENTS & PARTICIPATE IN TREATMENT PLAN: I will keep my scheduled appointments and actively participate in my treatment plan. I will attend behavioral and physical therapy sessions, if prescribed by my doctor. I will attend medication education classes, if requested to do so by my doctor.

FAILURE TO CANCEL OR RESCHEDULE WITHIN 24 HOURS OF YOUR APPOINTMENT WILL RESULT WITH THE FOLLOWING FEES: $95.00 FOR FOLLOW UP VISIT ---- $195.00 INJECTION APPOINTMENT

12. USE OF THE EMERGENCY DEPARTMENT/ROOM: I understand that the management of chronic pain cannot be done through visits to the emergency room. I will not go to the emergency room unless I have a true medical emergency. If I go to the emergency room for a true medical emergency, I agree to tell my doctor about the event of my visit to the emergency room within 48 hours of my discharge (or have a family member do so if I am unable).

13. PRESCRIPTION REFILLS: I understand that my prescriptions will only be refilled (or renewed) during scheduled office visits and regular business hours. I understand that it is my responsibility to keep track of my supply of pain medication and to make timely appointments with my doctor to have my treatment progress evaluated.

14. HONEST COMMUNICATION: I will be completely honest with my doctor about the nature of my pain and its impact on my daily life. I will contact my doctor if I experience any side effects from the medications prescribed to me.

15. SPECIFIC CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION: I understand that my doctor has several legal obligations associated with the prescribing of controlled medication and that he/she is subject to oversight by professional licensing boards and the US Drug Enforcement Administration. I also understand that it is important for my doctor to coordinate my care and use of controlled medications with other healthcare professionals, including my pharmacist and primary care doctor.

(a) I hereby authorize my doctor to cooperate fully with any city, state, or federal law enforcement agency, including this state's board of pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication.

(b) I hereby authorize my doctor to provide me a copy of this agreement to my pharmacy and to discuss facts specifically related to my filling and use of controlled medications with my pharmacist.

(c) I hereby authorize my doctor to provide a copy of this agreement to my primary care doctor and to discuss facts specifically related to my treatment plan and use of controlled medications with him/her.

Understanding Regarding Prescription Refills And Length Of Prescribing

Please review each statement.

I understand that my doctor has complete authority to determine whether there is a legitimate medical reason for me to use controlled medications for the treatment of pain and whether it is appropriate for me to continue using any such controlled medications.

I understand that I will only receive prescription refills or renewals if my doctor believes that the benefits of use outweigh the risks of use in my individual case.

I understand that my doctor may decide to discontinue prescribing controlled substances to me at any time if I do not make progress toward my treatment goals or if at any time the risks of using such medication appears to outweigh the benefits of the same.

Potential Consequences For Failure To Keep Treatment Agreement Promises

Please review each statement regarding the consequences for failure to comply with the treatment agreement.

I understand that my doctor may stop prescribing controlled medications and/or change my treatment plan if:

a. I do not show any improvement in pain from opioids or my physical activity has not improved.

b. My behavior is inconsistent with the responsibilities outlined above.

c. I give, sell or misuse the controlled medications prescribed to me.

d. I obtain controlled medications from any other source without the knowledge and written consent of my doctor.

e. I use illegal drugs or alcohol.

f. I refuse to cooperate when asked to provide a sample for a drug screen/test.

g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.

h. If I fail to keep appointments associated with this treatment plan.

i. If it is discovered that I have not been honest with my doctor regarding my medical history, use of controlled medications, history of substance abuse, prior medical records and treatments, or any other material fact relevant to my request for pain management from this practice.

By my signature below, I represent that I have read the Treatment Agreement, understand it, and agree to follow it with the awareness of the potential consequences if I do not do so.

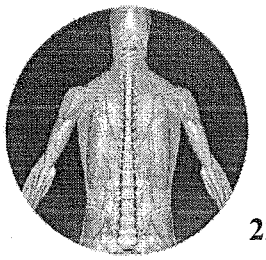
Date: _____ Patient Full Name (please print): _____

Patient Signature: _____

Doctor's Acknowledgment & Signature

Date: _____Doctor Full Name & Signature: _____

Neil R. Schultz, MD



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PATIENT NAME: _____ **DATE:** _____

PHYSICIAN/PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID/NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN

You have agreed to receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by local, state and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living.

- Alternative therapies and medications have been explained and offered to you. You have chosen opioid/narcotic therapy as one component of treatment.

The use of cigarettes demonstrates a dependence on nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to reduce your smoking or attempt a smoking cessation program.

You must be aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during the course of your treatment, you should contact your physician.

SIDE EFFECTS

Side effects are normal physical reactions to medications. Common side effects of opioids/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried or they may be discontinued.

You should **NOT**:

a. operate a vehicle or machinery if the medication makes you drowsy;
b. consume **ANY** alcohol while taking opioids/narcotics; or
c. take any other non-prescribed sedative medication while taking opioids/narcotics.

The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even death.

Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is **possible** that you could be considered DUI if stopped by law enforcement while driving.

Opioids have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects. Your hormone levels can be monitored during your treatment.

Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

PATIENT'S INITIALS: _____

RISKS

Dependence

Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life-threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

Tolerance

Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain-relieving effect; upward adjustments during this period are not viewed as tolerance.

Increased Pain (Hyperalgesia)

The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an **increased** sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, actually note decreased pain after several weeks off of the medications.

Addiction

Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following:

- impaired control over drug use;
- compulsive use;
- continued use despite harm; and/or
- craving.

Most patients with chronic pain who use long-term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy. Therefore, they are **NOT** addicted. **Physical dependence** is **NOT** the same as addiction.

Risk to Unborn Children

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

Long-Term Side Effects

The long-term effect of opioid/narcotic therapy is not fully known. Most of the long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

PATIENT'S INITIALS: _____

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS

Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided with enough medication on a monthly basis, two-month basis, or three-month basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will **not** be "called in" to the pharmacy.

You agree that you must be seen by your physician at a minimum of every three months during the course of your therapy.

You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.

You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should NEVER be given to others.

You agree to fill opioid/narcotic prescriptions at one pharmacy.

You agree to secure your opioid/narcotic medications in safe, locked source to prevent loss or theft. You are responsible for any loss of theft.

You agree that lost, stolen or destroyed prescriptions or drugs **will not** be replaced, and may result in discontinuation of treatment.

You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.

You agree to submit to an initial examination and evaluation, to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), and to examination and evaluation at the direction of your physician.

You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. **You also agree** that other doctors and law enforcement may be notified of the results.

You agree NOT to call the physician for refills or replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement requests will be addressed during regular business hours only.

You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. **You further understand and agree that you are solely responsible for your own medications.**

You agree to bring all prescription medications in their bottles or containers to the office during regularly scheduled visits.

You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

PATIENT'S INITIALS: _____

OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

- develop progressive tolerance which cannot be managed by changing medications;
- experience unacceptable side effects which cannot be controlled;
- experience diminishing function or poor pain control;
- develop signs of addiction;
- abuse any other controlled substance (this may be determined by random blood/urine testing);
- obtain and or use street drugs (this may be determined by random blood/urine testing);
- increase your medication without the consent of your physician;
- either refuse to decrease smoking or refusal to stop smoking;
- obtain opiates/narcotics from other physicians or sources;
- fill prescriptions at other pharmacies without explanation;
- sell, give away, or lose medications;
- fail to submit to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), or as directed by your physician;
- **fail to bring your prescription medications to your regularly scheduled visits;**
- fail to submit to blood/urine testing as directed;
- call for refills during evenings, weekends or holidays; or
- violate any of the terms of this agreement.

By signing below, I acknowledge and agree that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for long-term opioid/narcotic therapy for the treatment of chronic pain; (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement.

YOU MUST BRING YOUR OPIOID/NARCOTIC MEDICATIONS WITH YOU TO EACH OFFICE VISIT.

THIS INCLUDES ALL OF THE PILLS THAT YOU HAVE REMAINING AND THE MEDICATION BOTTLE.

FAILURE OR REFUSAL TO DO SO MAY RESULT IN DISCONTINUATION.

Patient Signature: _____ **Date** _____

Print Name: _____

Physician Signature _____ **Date** _____

Print Name: **Neil R. Schultz, MD**