COMPTON CHIROPRACTIC CARE | COMPTON INTERNAL MEDICINE CARE | INTERVENTIONAL PAIN INSTITUTE

11974 CR 101, STE 101 & 102

The Villages, FL 32162

(352) 350-6500 Phone (352) 391-9468 Fax

Please send the following to our office via the methods listed below:

melissa@comptoncarefl.com

Fax (352) 391-9468

- Picture of Drivers License and Insurance Cards (front and back)
- **Completed** Intake Paperwork
- Recent lab work, imaging, or other testing please send report.
- Please send copies all reports to melissa@comptoncarefl.com

Failure to have all Intake paperwork COMPLETED PRIOR to your appointment time may result in your appointment being rescheduled.

Please contact the office if you have any questions

(352) 391-9467 or (352) 350-6500

AFTER HOURS PHONE NUMBER FOR URGENT MATTERS ONLY

(SEE OFFICE POLICIES FOR DETAILS) (352) 461-8406

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

COMPTON INTERNAL MEDICINE CARE

INTERVENTIONAL PAIN INSTITUTE

COMPTON CHIROPRACTIC CARE

Legal Name: _____ Prefers: _____ Gender: M / F

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Social Security #: _____ Birthdate: ____/_____/_____ □ Married □ Single □ Widowed □ Divorced

Emergency Contact : _____ Contact Number : _____

PCP Name: _____ Preferred Pharmacy & Location_____

Other Specialists: _____

Consent to Treat

_____ **Initials**

I hereby voluntarily consent to all healthcare services ordered/provided by our office. The health care ser vice may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and test; x-rays and other imaging studies; administration of medications; and alternative healthcare prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services. I consent to examinations, treatments, procedures and blood test ordered by the healthcare provider, which may include blood test for diseases such as hepatitis and HIV AIDS. I understand that if this consent is being signed on behalf of a minor, I may be required to sign a separate paternal consent form in order for the minor to receive family planning services. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and ask me to complete a new consent form.

Consent Provisions

_____ **Initials**

My initials on this form indicate that: 1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true. 2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity. 3. I understand that Resident Physicians and other Licensed Healthcare Practitioners may be involved in treatment and I consent there to. 4. I understand that midlevel providers (Physicians Assistants and Advanced Practice Registered Nurses) may be involved in treatment and I consent there to. 5. I understand that I may be asked to sign a separate informed consent form for certain treatment/procedure (s) that require such. 6. I hereby voluntarily give my consent to treatment at our office.

Consent to Bill Insurance and Collect Payment

_____ **Initials**

I understand and agree that health insurance coverage is an agreement between the insurance carrier and myself. I understand that our office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized will be paid directly to our office. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I authorized said office to furnish information to insurance carriers concerning my illness and treatments. I acknowledge my responsibility to pay for that care according to the fees established. In the event that the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein. HIPAA Acknowledgement of Privacy Practices I have received a copy of our offices "Notice of Client Privacy Rights." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Patient Name _____ Patient Signature _____ Date _____

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

COMPTON INTERNAL MEDICINE CARE

INTERVENTIONAL PAIN INSTITUTE

Office Policies

It is our mission to efficiently provide high-quality, comprehensive, medical care to you—our valued patient. To achieve this goal we request all patients adhere to the following administrative policies. Your cooperation is greatly appreciated. Non-compliance with the practice policies may result in fees as stated below.

Fees

1. If you cannot keep an appointment, you are responsible for notifying the office a minimum of 24 hours in advance. **Fee for missed appointment without notifying office.** _____ **$60.00**
2. We accept cash, check, credit, and debit cards. **Returned check fee** _____ **$35.00**
3. Unaddressed overdue bills of 120+ days will be sent to collections. **Collection Fee** _____ **$50.00**
4. Forms— Completion of health forms requiring a physician signature **Form Fee** _____ **$30.00**
5. Credit Card Processing Fee. 3.5 % Processing fee applied to all terminal transactions _____ **3.5%**

Medication Refills

- Please request your medication refills at the time of your appointments. This provides patients with the most timely refill services.
- Allow **2 business days** to process refill requests.
- **Please Note—** medications prescribed elsewhere (i.e. : specialist) must be refilled by original ordering physician unless previously approved by your provider.

- It is the patients responsibility to provide our office with all necessary documentation, imaging, and lab/testing results preformed elsewhere.
- Controlled Substances require PMR and may be subject to random UDS
- After hour calls will be answered by our answering service for URGENT (but non Emergency) CALLS ONLY; for EMERGENCIES DIAL 911. When you call our office at (352) 461-8406, please leave a voicemail as directed and the on call doctor will return your call. Medication refill requests do not constitute an urgent after hours matter. For cancellations or changes of appointments, please call the office during normal business hours. Medications **WILL NOT** be refilled on weekends or holidays. It is the patients sole responsibility to notify our office during business hours for medication refills.

I have read, understand, and agree to the above office policies.

Patient Name _____ Patient Signature _____ Date _____

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

COMPTON INTERNAL MEDICINE CARE

INTERVENTIONAL PAIN INSTITUTE

COMPTON CHIROPRACTIC CARE

PATIENT NAME: _____ DATE: _____

WELLNESS SCREENING HISTORY : DATE

Wellness/Routine Physical Exam	
Colonoscopy	
Mammogram	
DEXA (Bone Density) Scan	
Pap Smear	
PSA	
Hepatitis C Screening	
Diabetic Eye Exam	

ADULT VACCINATION/IMMUNIAZTION HISTORY

TETANUS	
TDAP	
PREVINAR 13	
ZOSTER	
SHINGLES	
PNEUMOVAX 23	

Social/History

Tobacco: □ Never □ Prior Use: Quit Date: _____

Alcohol: □ None □ Social □ Daily; Drinks per week _____

Same sex intercourse: □ Yes □ No

Family Medical History: Father: _____ Mother: _____

Occupation: _____

HEALTH HISTORY—HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? **Reconciled □**

□ Measles/Mumps	□ Gout	□ Seizures/Epilepsy	□ Bone/Joint Disorder	□ Pneumonia
□ Chicken Pox	□ Stomach Ulcer	□ Parkinson's Disease	□ Eye Disease	□ Asthma
□ Rheumatic Fever	□ Reflux Disease	□ Multiple Sclerosis	□ Glaucoma	□ Seasonal Allergies
□ Scarlett Fever	□ Gall Bladder Issues	□ High Blood Pressure	□ Kidney Disease	□ Emphysema/COPD
□ Polio	□ Pancreatitis	□ Stroke/TIA	□ Kidney Stone	□ Pulmonary Clotting
□ Lyme Disease	□ Colitis	□ Heart Disease/CAD	□ Urinary Disorders	□ Depression
□ Tuberculosis	□ Diverticulitis	□ Heart Attack	□ Erectile Dysfunction	□ Anxiety
□ Diabetes	□ Irritable Bowel	□ Heart Murmur	□ Prostate Disease	□ Eating Disorder
□ Sleep Apnea	□ Hepatitis	□ Heart Failure	□ Reproductive Issues	□ Psychiatric Care
□ Anemia	□ Liver Disease	□ High Cholesterol	□ Menstrual Problems	□ Drug Addiction
□ Bleeding Disorder	□ Thyroid Disease	□ Arthritis	□ Vaginal Infection	□ Alcoholism
□ Blood Clots	□ Migraines/Headaches	□ Osteoporosis	□ Breast Lump	□ Sexual Dysfunction
□ Cancer _____	□ Auto Immune Disease _____	□ Peripheral Vascular Disease	□ Skin Disease _____	□ STD _____

OFFICE USE ONLY: Vitals: Ht _____ Wgt _____ PO% _____ BP (rt)_____ P _____ BP (lt) _____ P _____ Temp_____

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

INTERVENTIONAL PAIN INSTITUTE

COMPTON CHIROPRACTIC CARE

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

   I _____authorize the above office to Obtain/Release medical information via mail, facsimile, or other appropriate secure means to:

   - □ Other healthcare providers involved in my care or to be involved
   - □ My Attorney
   - □ Family/Friend: _____, _____, _____,
   - □ Other: _____

2. Consent to view prescription history (PMP)
   Consent to view imaging, notes, test results from outside facilities
   Consent to communicate with patient via secure email or text for reminders and information

3. **Effective Period**: This authorization for release of information covers the period of healthcare from All past, present and future periods unless otherwise stated here: _____

4. Extent of Authorization

   ☑ I authorize the release of my **complete** health record (including records relating to mental healthcare, communicable diseases, HIV/AIDS and treatment of alcohol/drug abuse)

   I authorize the release of my complete health record with the **exception** of the following:

   - □ Mental health records
   - □ Alcohol/drug abuse treatment
   - □ Diagnosis/appointments
   - □ Communicable diseases (including HIV and AIDS)
   - □ Other (please specify): _____
   - □ Billing

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. I understand that I have the right to revoke this authorization, **in writing**, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Name _____ Patient Signature _____ Date _____

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

INTERVENTIONAL PAIN INSTITUTE

Patient Name: _____ Date: ___/___/___

CHIEF COMPLAINT **ALL FIELDS REQUIRED**

Chief Complaint: _____

Onset: (When did it happen?) _____

Mechanism of injury: (How did it happen?) _____

Palliative: (What makes the pain better?) _____

Provocative: (What makes the pain worse?) _____

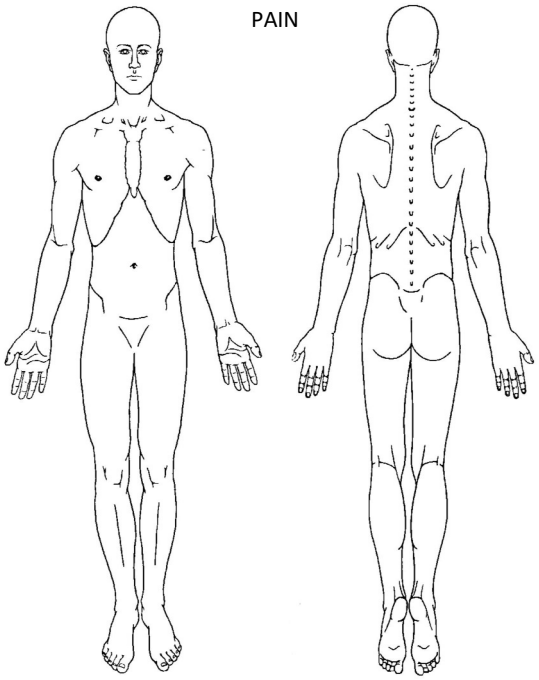
Quality: (Sharp, Burning, Achy, etc.)_____

Timing: (Is the pain worse in the morning or evening?) _____

Radiate (Does the pain travel?) :_____

Severity: Pain Now: ____/10 At its Worst:____/10

PLEASE DRAW PAIN



Prior Treatment: ANSWER YES, NO, CURRENTLY ACTIVE &/OR WAS IT HELPFUL

Home Exercises: _____

Physical Therapy: _____

Chiropractic: _____

Failed Medications: _____

Effective Medications: _____

Prior Pain Treatments, Injections, Surgeries: _____

_____

Patient Name: _____ DOB: _____

Patient Health Questionnaire-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use a check mark to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	_____ +	_____ +	_____ +	_____
			= Total Score:	_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0 1 2 3 4
2.	How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3.	How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.)?	0 1 2 3 4
5.	How often, in your lifetime have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers:

_____

_____

11974 CR 101 Suite 101-102 The Villages, FL 32162 (352) 350-6500 Phone (352) 391-9468 Fax

Full Name: _____ DOB: _____

Medication History

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, and dietary supplements.

1. Medication Name: _____ Dosage: _____ Frequency: _____
2. Medication Name: _____ Dosage: _____ Frequency: _____
3. Medication Name: _____ Dosage: _____ Frequency: _____
4. Medication Name: _____ Dosage: _____ Frequency: _____
5. Medication Name: _____ Dosage: _____ Frequency: _____
6. Medication Name: _____ Dosage: _____ Frequency: _____
7. Medication Name: _____ Dosage: _____ Frequency: _____
8. Medication Name: _____ Dosage: _____ Frequency: _____
9. Medication Name: _____ Dosage: _____ Frequency: _____
10. Medication Name: _____ Dosage: _____ Frequency: _____

Allergy Information

Please list any known allergies to medications, food, or other substances.

1. Allergen: _____ Reaction: _____
2. Allergen: _____ Reaction: _____
3. Allergen: _____ Reaction: _____

□ No known drug allergies

Surgical History

Please list any surgeries or major medical procedures you have undergone.

1. Surgery/Procedure: _____ Date: _____
2. Surgery/Procedure: _____ Date: _____
3. Surgery/Procedure: _____ Date: _____
4. Surgery/Procedure: _____ Date: _____

(Attach additional sheet if necessary)

INTERVENTIONAL PAIN INSTITUTE

PH: (352) 350-6500
FAX: (352) 391-9468
WWW.IPIMED.COM

PALM RIDGE PLAZA
11974 CR 101 Ste. 102, The Villages, FL 32162

18TH AVE MEDICAL PARK
1715 SE 28th Loop, Ocala, FL 34471

DRCOMPTON@IPIMED.COM

Informed consent and pain management agreement for controlled substances as required by state and federal guidelines.

TO THE PATIENT: As a patient you have the right to be informed about your condition(s), recommended medical/diagnostic/procedure and/or drug therapy to be used, so that you may make the informed decision whether or not to participate after knowing the risks and benefits involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you feel better informed so that you may give or withhold your consent/permission for any advised treatment recommended by me, as your physician or IPI providers. For the purposes of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other healthcare providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician and IPI treat my condition which has been explained to me in detail. I hereby authorize and give my voluntary consent for my physician and IPI to administer or write prescriptions which may include dangerous or controlled drugs (medications) as an element in the treatment of my acute or chronic pain. I understand I have other options including non-medication management with conservative care such as physical therapy, chiropractic, interventional pain techniques which may include injections or surgical procedures.

It has been explained to me that these medications may include opioid/narcotic drugs which can be harmful if taken with or without medical supervision. I further understand that these medications may lead to physical dependence and/or addiction. Furthermore, like other drugs used in the practice of medicine they may produce adverse side effects or results. The alternative methods of treatments, the possible risks involved, and the possibilities of complications have been explained to me as listed. 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 medications (especially if taken improperly).

The specific medications that my physician plans to prescribe will be described and documented separate from this agreement. This includes the use of medications for purposes different than what may have been approved by the drug company and the government (FDA). This is sometimes referred to as "off label" prescribing. I understand that my doctor will explain the treatment plan for me and document it in my medical chart.

I have been informed and understand that I will undergo medical tests and examinations before and during my treatment. Tests may include random unannounced checks for medications & psychological evaluations when it is deemed medically necessary. I hereby give permission to perform the tests and note that my refusal may lead to termination of treatment. The presence of unauthorized substances in my urine drug screen may result in being discharged from care and/or no longer receiving controlled substances.

I understand that the most common side effects that could occur in the use of the drugs used in my treatment include but are not limited to the following:

PH: (352) 350-6500
FAX: (352) 391-9468
WWW.IPIMED.COM

PALM RIDGE PLAZA
11974 CR 101 Ste. 102, The Villages, FL 32162

18TH AVE MEDICAL PARK
1715 SE 28th Loop, Ocala, FL 34471

DRCOMPTON@IPIMED.COM

Constipation, nausea, vomiting, excess drowsiness, itching, urinary retention, orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, impaired ability to operate a vehicle or machinery, respiratory depression (slow or no breathing), impotence, tolerance to medications, physical and emotional dependence or even addiction and death. I understand that I may be impaired during all activities including work. With this knowledge should I choose to operate a motor vehicle or machinery I do so under my own willfulness and responsibility therefore I hold my physician harmless.

The risk of addiction is increased in patients who have a prior history of addiction. Therefore, I will tell my doctor if I have such a history including addiction to cigarettes, smokeless tobacco, alcohol, gambling, etc. If I develop an addiction problem, I understand it is my responsibility to discuss with my doctor in order to obtain help with this. My doctor may decide that I should not continue on a particular medication or may decide that I may continue medication but only with very careful treatment guidelines.

The alternative methods of treatment, possible risks involved and possibilities of complications have been thoroughly explained to me. I still desire to receive evaluation and treatment for my acute/chronic condition.

The goal of treatment is to help me gain control of my condition/pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medications on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy and improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medications, but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medications. My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medications at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

Pain management agreement:

I understand and agree to the following:
This pain management agreement relates to my use of any and all medications (i.e. opioids aka narcotics, painkillers and other prescription medications, etc.) for treatment of acute/chronic pain as prescribed by my physician. I understand that there are federal and state laws/regulations/policies regarding the use and prescribing of controlled substances. Therefore, I understand medications will only be provided so long as I follow the rules specified in this agreement.

- My physician may at any time discontinue medications. Failure to comply with any of the following guidelines may result in discontinuation of medication and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior.
- My progress will be periodically reviewed and if medications are not improving my quality of life the medications may be discontinued.
- I will disclose to my physician all medications that I take at any time even if prescribed by another physician.

PH: (352) 350-6500
FAX: (352) 391-9468
WWW.IPIMED.COM

PALM RIDGE PLAZA
11974 CR 101 Ste. 102, The Villages, FL 32162

18TH AVE MEDICAL PARK
1715 SE 28th Loop, Ocala, FL 34471

DRCOMPTON@IPIMED.COM

- I will use the medications exactly as directed by my physician.
- I agree not to share, sell or otherwise permit others (which may include family member and friends) to have access to my medications.
- I will not allow or assist in the misuse/diversion of any of my medications, nor will I give or sell them to anyone else.
- All medications must be obtained at one pharmacy (when possible). Should the need arise to change my pharmacies, my physician must be informed. I will use only 1 pharmacy and I will provide my pharmacist a copy of this agreement if necessary. Furthermore, I authorize my physician to release my medical records to my pharmacist if necessary.
- I understand that my medications will be refilled on a regular basis if necessary. I understand that my prescriptions and medications are exactly like money and therefore if either are lost or stolen they may not be replaced.
- Refills will not be ordered before the scheduled refill date. However, early refills may be allowed when I am traveling and I make arrangements in advance of my planned departure date. I will make these arrangements at least 5 business days in advance otherwise I will not expect to receive additional medications prior to the time of my neck scheduled refill (even if I run out of my prescription medication).
- I will receive medications only from one physician unless it is for a true medical emergency or the medications that are being prescribed by another physician is approved by my physician (ex: Planned surgeries).
- If it appears to my physician that there are no objective benefits to my daily function or quality of life from medication, then my physician may try alternative medications or taper me off all medications. I will not hold my physician liable for problems caused by the discontinuance of said medications.
- I agree to submit to urine, blood, hair, or other screens as necessary to detect the use of non-prescribed and prescribed medications at any time with or without prior warning. If I test positive for illegal substances such as marijuana, speed, cocaine, methamphetamine, etc. I understand my medical treatment for my pain may be terminated. Also, a consult with or a referral to an expert may be necessary including qualified specialty physicians such as psychiatrists or addiction medicine providers.
- I understand that my physician will intermittently check the state/federal prescription monitoring program. This database will provide my physician with all controlled substance prescription medications that I have received. If my physician identifies problematic prescriptions or potential drug interactions, then this may be reason to discontinue medical therapy.
- I agree to intermittent paper/computerized psychological screenings as part of my medication monitoring. I also agree to any future risk reduction technology the practice may implement to prevent opioid misuse.
- I agree to return to the clinic with all my controlled substance pills during every office visit should my physician need to perform a pill count.
- I recognize that my pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care including chiropractic, etc. 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 pain management program recommended by my physician to achieve increased function and improve quality of life.
- **If applicable, I understand that routine use of nicotine-containing products alone can**

INTERVENTIONAL PAIN INSTITUTE

PH: (352) 350-6500
FAX: (352) 391-9468
WWW.IPIMED.COM

PALM RIDGE PLAZA
11974 CR 101 Ste. 102, The Villages, FL 32162

18TH AVE MEDICAL PARK
1715 SE 28th Loop, Ocala, FL 34471

DRCOMPTON@IPIMED.COM

create increased pain due to the neuro chemical sensitization of nerve fibers from chronic nicotine use.

- I agree I shall inform any current or future doctor who may treat me for any medical purpose that I am enrolled in a pain management program with IPI.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physicians and pharmacist regarding my use of medications prescribed by my physicians.
- I must take the medication as instructed by my physician. Any unauthorized increase in the dose or frequency of the medication may be viewed as a cause for discontinuation of treatment.
- I must keep all follow-up appointments as recommended by my physician or my treatment plan may be discontinued.

I certify and agree to the above and following:

1. I am not currently using illegal drugs, abusing prescription medications, or undergoing treatment for substance dependence/addiction/abuse at this time. I am reading and making this agreement while in full position of my faculties and not under the influence of any substance that may impair my judgment.
2. I have never been involved in the sale, illegal position, misuse/diversion or transport of controlled or illegal substances.
3. I understand that no warranty or guarantee has been made to me as the results of any treatment. The long-term use of medications to treat pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity ask questions about my condition and treatment, risks of non-treatment, drug therapy, medical treatment/diagnostic procedures and the risks/hazards of such drug therapy/treatment/procedures. I have reviewed the side effects of the medications that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and risks of these medications and therapies and I agreed to the use of these medications/therapies in the treatment of my condition.
4. I believe I have sufficient information to give this informed consent.

For female patients only:

To the best of my knowledge **I am not pregnant**. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment if necessary. I except that this is my responsibility to inform my physician immediately if I become pregnant. If I am pregnant or am uncertain, I will notify my physician immediately. At present, there have not been enough studies conducted on the long-term use of many medications including opioids/narcotics in order to ensure complete safety to my unborn child/children. With full knowledge of this, I still consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

_____ _____

Patient Signature: Date:

_____

Physician signature or appropriately authorized assistant: