PATIENT INFORMATION

FIRST NAME _____ MI ____ LAST NAME _____

EMAIL ADDRESS: _____ MAIDEN/PREVIOUS NAME: _____

ADDRESS: _____ APT/UNIT _____

CITY: _____ ST ____ ZIP CODE _____

PHONES: HOME _____ MOBILE _____ WORK _____

DATE OF BIRTH _____ SEX ◇ M ◇ F MARITAL STATUS ◇ S ◇ M ◇ D ◇ W

SSN _____ PRIMARY CARE MD _____

EMERGENCY CONTACT NAME _____ PHONE _____

FINANCIAL GUARANTOR NAME _____ PHONE _____

PRIMARY INS COMPANY _____ ID _____ GROUP _____

POLICY HOLDER'S NAME _____ DOB _____ SSN _____

SECONDARY INS COMPANY _____ ID _____ GROUP _____

POLICY HOLDER'S NAME _____ DOB _____ SSN _____

WORKERS' COMPENSATION COMPANY _____ DATE OF INJURY _____

ADJUSTER NAME _____ TEL _____ FAX _____

AUTO ACCIDENT CLAIM INS COMPANY _____ DATE OF INJURY _____

CONTACT NAME _____ TEL _____ FAX _____

CLAIM NUMBER _____ INJURY _____

BILLING ADDRESS _____ CITY _____ ST ____ ZIP _____

I authorize the payment of any insurance benefits for health care services to Advanced Pain and Anesthesia PC. Note: If the patient is a minor under the age of 18 years, this form must be signed by the patient's parent or legal guardian.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

NEW PATIENT HISTORY FORM

Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____ Are you legally disabled? O Yes O No

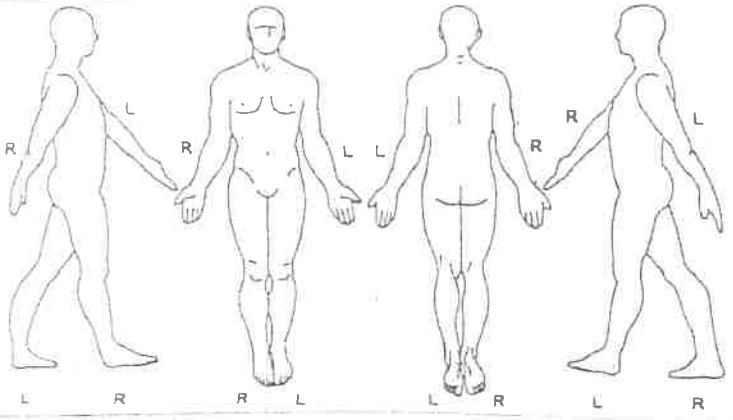
Primary Care MD: _____ Referred to us by: _____

What is the reason for your visit? O Pain O Numbness O Other, please explain: _____

When did this problem begin? _____ How did it start: O Injury O Auto Accident O Sports O No Specific Cause

Please explain: _____

What area of your body is affected? O Right O Left Please circle the affected area(s) on the diagram. Use an **X** to show where it hurts the most.



What kind of pain do you feel? O Dull Ache O Burning O Throbbing O Sharp O Nagging

Associated problems? O Numbness O Tingling O Swelling O Stiffness O Bowel/Bladder Control Problems

How often to the symptoms occur? O On and Off O Constant O When Sleeping O Other

What makes the pain better? _____ What makes the pain worse? _____

Pain Level (0=No Pain, 10=Worst Pain) Right Now: _____ Lowest in the Last Month: _____ Highest in the Last Month: _____

What treatments/therapies have you tried?	Was it helpful?		
O Rest	O Yes	O No	
O Pain Clinic	O Yes	O No	MD name: _____
O Chiropractor	O Yes	O No	
O Injections	O Yes	O No	What kind? _____
O Acupuncture	O Yes	O No	
O TENS Unit	O Yes	O No	
O Physical Therapy	O Yes	O No	How long? _____
O Surgery	O Yes	O No	Please list on page two under Surgical History.
O Medications	O Yes	O No	Please list on page two under Medication List.

Please indicate what diagnostic tests you've have:

Test	X-Ray	MRI	CT Scan	EMG/NCS	Other
Body Area					
Date					
Facility					

New Patient History - Page Two

Medication Allergies? ○ None ○ Penicillin ○ Sulfa ○ Aspirin ○ Codeine ○ Other, please list:

_____

Other Allergies? ○ Yes ○ No Please list: _____

MEDICATION LIST (please list CURRENT medications only)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL HISTORY (please list date, body area and surgery type)

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

MEDICAL CONDITIONS Do you currently experience any of the following? Please check all that apply.

GENERAL
- ○ Weight Loss
- ○ Fevers
- ○ Fatigue

EYES
- ○ Need/Wear Glasses
- ○ Wear Contacts
- ○ Glaucoma

SKIN
- ○ Rash
- ○ Blisters

CARDIOVASCULAR
- ○ Heart Murmur
- ○ Chest Pain
- ○ Irregular Heartbeat

EARS/NOSE/THROAT
- ○ Hearing Loss
- ○ Sinus Infections

IMMUNOLOGIC
- ○ Tuberculosis
- ○ HIV/Hepatitis
- ○ Cancer

GASTROINTESTINAL
- ○ Heartburn
- ○ Stomach Ulcer

RESPIRATORY
- ○ Shortness of Breath
- ○ Sleep Apnea
- ○ Asthma
- ○ COPD/Emphysema

HEMATOLOGIC
- ○ Bleeding Disorder
- ○ Blood Clots

MUSCULOSKELETAL
- ○ Arthritis
- ○ Osteoporosis
- ○ Prior Bone Fracture

URINARY
- ○ Painful Urinating
- ○ Frequent Urinating
- ○ Infection

ENDOCRIN
- ○ Thyroid Issue
- ○ Diabetes

NEUROLOGIC
- ○ Balance Problems
- ○ Dizziness
- ○ Headaches
- ○ Seizures
- ○ Weakness
- ○ Dementia
- ○ Parkinson's

PHYSCHIATRIC
- ○ Depression
- ○ Anxiety
- ○ Panic Attacks

FAMILY HISTORY ○ Heart Disease ○ High Blood Pressure ○ Diabetes ○ Cancer ○ Arthritis ○ Stroke

SOCIAL HISTORY ○ Single ○ Married ○ Divorced ○ Widowed ○ Right-Handed ○ Left-Handed ○ Ambidextrous

Alcohol Use: ○ None ○ Occasional ○ Frequent Smoking: ○ No ○ Yes ____ Packs/Day Recreational Drugs ○ Yes ○ No

What are your interests and hobbies? _____

_____ _____

Patient/Parent/Guardian Signature Date

Authorization for Release of Information

Patient Name: _____ DOB: _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other: _____
☐ Spouse (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Email communication (provide email address)* _____	☐ Financial ☐ Medical ☐ Breach Notification

*In order for email communication to occur, please accept the disclosure below:

_____ Initial I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

X _____ _____

Signature of Patient or Personal Representative — Date

_____

Description of Personal Representative's Authority (attach necessary documentation)

ADVANCED PAIN AND ANESTHESIA SERVICES

PEAK ANESTHESIA AND PAIN MANAGEMENT

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Advanced Pain and Anesthesia Services/ Peak Anesthesia and Pain Management (the provider of medical services) and the Patient who is receiving medical services, or Responsible Party for minor patients (those patients under the age of 18). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of services.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as The Responsible Party must:

- Inform use of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When we receive an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy

If a payment is made on an account by check and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or Patients Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the Patients Responsible Party, understands that APAS has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the Patients Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and collection fee will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patients Name(Print)_____

Patients Signature_____ Date_____

Responsible Party Name(Print)_____

Responsible Party Signature_____ Date_____

PEAK ANESTHESIA & PAIN MANAGEMENT
ADVANCED PAIN & ANESTHESIA SERVICES
145 Inverness Drive East, Suite 350
Englewood, CO 80112
TEL 720-870-7446 -- FAX 720-870-7460

Cancellation Policy

We understand that there will be circumstances that may require you to cancel or reschedule your appointment. Our physicians are prepared to provide you with your scheduled treatment. When you cancel on short notice or miss an appointment, we are left with an open time that someone else could have used.

Please initial next to each line indicating you have read and understood our cancellation policy.

____ If you need to cancel your appointment, we request a 24 hour notification

____ Appointments cancelled or missed with less than 24 hour notice will be assessed the following fee:
$75 new patient visit $75 injection procedure or EMG $45 follow up visit

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Financial Policy

The fees charged in our office are comparable to those charged by other pain specialists in this area.

If you do not have insurance: All payments are due and payable at the time services are rendered.

Co-Payment/Co-Insurance Policies: We are obligated by law to collect your carrier designated fees. We will verify your insurance benefits to the best of our ability. Please understand that this does not guarantee benefits. You, the patient, are ultimately financially responsible for the care you receive in this office. We will do our best to communicate with you in a timely manner regarding any issue with your insurance policy and will work on your behalf to resolve these issues.

- We accept cash, checks, Visa and Mastercard as forms of payment.
- If you need a payment plan, please contact our billing office to set up.
- Any returned checks will be charged a $25.00 fee in addition to the amount of the check

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I certify that I have read and understand the information listed above. I understand that it is my responsibility to ask questions regarding these policies if my understanding is unclear.

Patient Signature: _____ Date: _____

Peak Anesthesia & Pain Management/Advanced Pain & Anesthesia Svcs
Authorization to Release Health Information

Patient Name (list previous name if changed) _____ Date of Birth _____

Telephone _____ Social Security _____

Send Records to: Peak Anesthesia & Pain Management or Advanced Pain & Anesthesia
145 Inverness Drive East, Suite 350, Englewood, CO 80112

Other Provider:

Provider/Practice Name _____ Phone _____

Address _____ Fax _____

City, State, Zip Code _____

I [ ] do [ ] do not (check applicable box) authorize this information to be faxed.
If yes, fax number: 720-870-7460

This information is being disclosed for the purpose of Continuing Health Care.

For Healthcare Covering the Period(s) [ ] All or From: _____ To: _____

[ ] Complete Health Record to be disclosed or (check appropriate boxes):
[ ] History & Physical Exam [ ] Progress Notes [ ] Discharge Summary
[ ] X-Rays / Ultrasounds [ ] Laboratory Tests [ ] Consultations

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein. I understand that The Medical Records Department at Peak Anesthesia and Pain Management has 30 days to respond to this request.
Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may a fee for preparing and furnishing thus information.

Signature of Patient or Legal Representative _____ Relationship to Patient _____ Date _____

Notice of Privacy Practices for Protected Health Information
Peak Anesthesia & Pain Management

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!

Effective date: December 2011

The Practice of Peak Anesthesia & Pain Management is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclosure your PHI for the purposes of treatment, payment, and health care operations without your written authorization.

Examples of Uses of Your Health Information for Treatment Purposes are:
- Our nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition, or to remind you of medical appointments.

Example of a Use of Your Health Information for Payment Purposes:
- We submit requests for payment to your health insurance company; the health insurance company requests information from us regarding medical care provided to you. We will provide this information to them.

Example of a Use of Your Information for Health Care Operations:
- We may use or disclose your PHI in order to conduct certain business and operational activities such as quality assessment activities, to review employee activities, or to assist in the training of students. We may share information about you with our business associates, who perform these functions on our behalf, as necessary to obtain these services.

Other Examples:
- We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use or disclose your PHI for activities such as sending you a newsletter about our practice and the services we offer. You may contact us to request that these materials not be sent to you.

Other uses and disclosure of your PHI will only be made with your authorization, unless otherwise permitted or required by law, as described below.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in them, however, belongs to you. You have a right to:
- Request a restriction on certain uses and disclosures of your health information. We are not required to grant the request, but we will comply with any request that we agree to grant;

- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("the Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that either was not created by us (unless the person or entity that created the information is no longer available to make the amendment), is not part of the health information kept by the office, is not part of the information that you would be permitted to inspect and copy, or is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Restrict information going to your health plan about an item or service for which you pay the Practice out-of-pocket and in full for the item or service.
- Obtain an accounting of disclosures of your health information as required to be maintained by law. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

If you would like to exercise any of the above rights, please contact Desiree Sidwell at (720) 870-7446 during regular business hours, or in writing. The Privacy Officer will inform you of the steps needed to exercise your rights under HIPAA.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice ('Notice') as to our duties and privacy practices regarding the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you and not disclose PHI to your health plan if you request that we do not, and pay for the item/service out-of-pocket and in full. You must request this Patient Right in writing.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy, visiting our website, or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or would like to report a problem regarding the handling of your information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you may file a complaint by delivering it in writing to the Practice's Privacy Officer. You

may also file a complaint with the Secretary of Health and Human Services, Office for Civil Rights (OCR). The address for this office is: OCR - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201. Information regarding the steps to file a complaint with the OCR can also be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object, or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Enforcement

- We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization. You may revoke any authorization at any time, as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, you will be able to access our Notice electronically on our website.

PATIENT SIGNATURE SECTION:

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received the attached (above) Notice of Privacy Practices ("The Notice") for the practice of Peak Anesthesia & Pain Management

_____
Print Name

_____ _____
Patient (or Patient Representative*) Signature Date

****If Patient Representative, legal documentation must be included to show authority to sign or receive information.*

Peak Anesthesia and Pain Management
Advanced Pain and Anesthesia Services
(720) 870-7446

145 Inverness Drive East, Suite 350
Englewood, CO 80112
1610 Prairie Center Pkwy, Suite 2230
Brighton, CO 80601

PAIN MANAGEMENT AGREEMENT

Pain Management Agreement between _____ and Peak Anesthesia and Pain
Print patient name

Management /Advanced Pain and Anesthesia Services. _____
Print physician name

The purpose of this Agreement is to prevent misunderstandings regarding my treatment for chronic pain and about certain medicines I may be prescribed or pain management. This is to help both myself and my provider comply with the law regarding controlled medications, and Peak Anesthesia and Pain Management's practice policies.

This agreement relates to my use of controlled substances for chronic pain prescribed by a physician at Peak Anesthesia and Pain Management (PAPM). I have been informed and understand the policies regarding the use of controlled substances that are followed by the physicians and staff at PAPM. I understand that I may be prescribed controlled substances only if I adhere to the following conditions. My physician's goal is for me to have the best quality of life possible given the reality of my clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

Opioid is a generic term referring to medications which have been derived, either naturally or synthetically, from opium and are used for the treatment of pain. These medications are generally considered narcotics.

1. I understand that my provider and I will continually evaluate the effect of opioids and other medications and/or therapies on achieving the treatment goals and make changes as needed. I agree to take the medication at the DOSE and FREQUENCY prescribed by my provider. If I feel my prescription dose or frequency needs adjustment I will make an office visit appointment to discuss this with my provider. I agree not to increase the dose or frequency of my medications on my own and understand that doing so may result in termination of the doctor/patient relationship.

2. I will attend all appointments, treatments and consultations as requested by my providers. I will attend all refill appointments and follow pain management recommendations. Three or more missed appointments or same-day cancellations will result in termination of the doctor/patient relationship.

3. I will tell my providers about the level and quality of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve my pain.

4. For female patients: If I plan to become pregnant or believe that I have become pregnant while taking medications, I am aware that, should I carry the baby to delivery while taking opioids, the baby will be physically dependent upon opioids. I will immediately call my obstetrician and PAPM to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though this is extremely rare.

5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain-control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition. If treatment for my condition is available, I agree I will not refuse treatment just to continue with opioid therapy. I understand that I have the right to refuse any procedure or therapy, but that does not mean that my provider must continue to prescribe narcotic or opioid medications.

6. I understand that a pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically-based coping strategies taught to me may lead to discontinuation of the doctor/patient relationship.

7. The risks and benefits of taking opioid medications have been explained to me. I understand them. Side effects may include skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, and impaired cognition (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing). I agree to not participate in activities that would endanger me or others while using these medications.

8. I agree to inform my physician of all medications I am taking, including herbal and over-the-counter remedies, since opioid medications can interact with them, especially cough syrup that contains alcohol, codeine or hydrocodone.

9. If I have a history of alcohol or drug misuse/addiction, I must notify my physician of this history as treatment with opioids for my pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.

10. I agree I will not use any illegal controlled substances, including cocaine, heroin, methamphetamine, unlicensed marijuana, etc. I agree I will not abuse alcohol. If my provider advises, I will not use any alcohol. I agree I will not use any prescription medications obtained illegally, or obtain them from anyone, including friends or relatives. Nor will I share sell or trade my medication with ANYONE and understand that doing so will result in termination of the doctor/patient relationship.

11. I understand that I am responsible for keeping my medications in a safe and secure place, such as a locked cabinet or safe. I know I am expected to protect my medications from loss or theft. I will immediately report stolen medications to the police and my physician. If my medications are lost, misplaced or stolen, I realize that my physician may choose not to replace them or to taper and discontinue them. I understand that no opioid medications I report as stolen will be replaced without a police report.

12. I agree I will not attempt to obtain any opioid medicine from another doctor or provider without informing PAPM first.I discussed the risks of opioid medications for pain management. These risks included addiction, substance abuse, medication tolerance, physical dependence, respiratory depression, constipation, nausea, and an opiate-induced hyperalgesia state (increase in pain from opiate medications) and possible death. The patient was also advised to keep the medication in a safe place. He was advised not to drink alcohol using this medication. The patient has been informed that Advanced Pain Anesthesia Services conforms to all the recommendations from the Colorado Medical Board. Specific risks were discussed with the patient including operating a vehicle while taking opiates because of increased risk of a motor vehicle accident. We discussed how tolerance limits the efficacy of Opioids for long-term pain management. I agree to have my opioid prescriptions filled at _____, (____) _____ - _____.
Pharmacy name/location Pharmacy phone

13. I understand that if my regular PAPM physician is unable to be present for a scheduled appointment that the other physicians and staff of PAPM will make every reasonable effort to ensure that I am able to continue my pain management program without interruption.

14. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings after 4:00 PM, or on weekends, holidays, or through an emergency or urgent care facility. Medications will not be refilled without being seen at the clinic for a regular monthly appointment.

15. I will be given a (30) thirty-day supply of my opioid prescriptions each month. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner, so I will not run out of medication. I understand that failing to do so may result in late refill as an appointment for refill may not be available prior to the refill date.

16. I understand that early refills will not be written and appointments more than five days prior to my refill date will not be scheduled. Nor will I request refills by telephone. My doctor may, at his/her own discretion, waive these rules for extenuating circumstances.

17. I agree to bring in all unused medicine when requested so that the clinic staff may dispose of it properly. I understand that I may not receive a new medication without surrendering the unused portion of any medication it is intended to replace.

18. I will submit urine, blood, or saliva for drug testing if requested by my provider to determine my compliance with their program of pain control. I understand that refusal to do so will result in the termination of the doctor/patient relationship.

19. The presence of a non-prescribed drug or illicit drug, or the absence of prescribed medications, in my urine, blood or saliva is grounds for termination of the doctor/patient relationship.

20. I authorize PAPM to cooperate fully with any official, including the state's Board of Pharmacy and local law enforcement, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

21. In the event I am arrested or incarcerated related to legal or illegal drugs (including alcohol); refills of controlled substances will not be given.

22. I will accept generic brands of my prescription medications.

23. I understand that I may become physically dependent on, addicted to, tolerant or have complications from opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will accept referral to addiction specialists or a detox program.

    Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in mood.

    It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

    Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and cravings. This means the drug *decreases* one's quality of life.

    Tolerance means a state of adaptation in which exposure to the drug induces changes that result in lessening of one or more of a drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

25. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from a controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician.

26. I understand that if I violate any of the above conditions, my provider may choose to stop writing opioid prescriptions for me. Discontinuation of the medications will be coordinated by the provider and may require specialist referrals and/or a termination of the doctor/patient relationship.

27. I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering or forging a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate and that the doctor/patient relationship will be terminated.

28. I understand that suddenly stopping some medications can cause problems such as: withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

29. I understand that I will pay all bills and invoices due to the practice. If I fail to pay my balance due this will be grounds for termination from the practice. If terminated from the practice due to failure to pay balance you will be given a thirty (30) day supply of your medication and will receive no further medications from the practice.

Medication Refill Information:

- Advance notice of (4) four business days is required for all non-opioid prescription refills.
- Requests for scheduled refills of non-opioid prescriptions must made through the pharmacy indicated in Number 13 above. Refills will not be made in the evening, on holidays, or on weekends.
- Most controlled substances cannot be phoned in to a pharmacy.
- I will be given a (30) thirty-day supply of my opioid prescriptions each month.
- All hard copies of opioid prescriptions must be hand delivered to the pharmacy by myself or my designated family member/caregiver.

145 Inverness Drive East, Suite 350
Englewood, CO 80112
1610 Prairie Center Pkwy, Suite 2230
Brighton, CO 80601

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

- This agreement supersedes all other agreements.
- By signing below I affirm that I understand AND agree to ALL the terms of the above agreement. I have full right and power to sign and be bound by this agreement. I have received a copy of this for my own reference and records.

Patient _____ Name _____ Signature

Caregiver *(Optional)* _____ Name/Relationship _____ Signature

Provider _____ Name _____ Signature

Date _____/_____/_____

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1. _____ Dismissal Letter Sent:
2. _____
3. _____