ACCIDENT INJURY FORM

Patient: _____ DOB: _____

Date: _____

1. **INJURY/ACCIDENT DETAIL** (this form must be completed, signed and dated)

Many insurance companies require accident/injury details after they receive our claim. Please answer the following questions and explain how this accident/injury occurred.

Is this claim related to an accident _____ Yes _____ No ***If yes please proceed to section 2**

If no, please describe your symptoms, when they started and how long they have been present.

_____

_____

2. **If AUTO, MOTORCYCLE, WORK OR OTHER ACCIDENT please CHECK one of the following:**

_____ AUTO _____ MOTORCYCLE _____ WORK _____ OTHER

Date of this accident? _____

State the accident occurred in: _____

Insurance Carrier: _____

Employer (if work related): _____

Claim #: _____

Adjuster: _____

Adjuster Phone: _____ Adjuster Fax: _____

To the best of my knowledge the above information is true, accurate and complete. Unanswered questions indicate they do not apply. I also understand that my signature authorizes the release of this information to my insurance carrier or carriers.

Signature: _____ Date: _____

YOUR INFORMATI ON

Full Name:

Date of Birth: ___/___/___ **Age:** _____

Height: **Weight:**

Preferred Language?

Email:

Who may we thank for this referral (please circle) Physician Family Friend Website Other:

Primary Care Physician:

Cardiologist:

Employment Status
- Full Time
- Part Time
- Retired
- Student
- Disabled
- Military

Marital Status
- Married
- Single
- Divorced
- Widowed
- Life Partner

Race
- African American
- Asian
- Caucasian
- Hispanic
- Other

Ethnicity
- Hispanic
- Non-Hispanic

Living Status
- Lives Alone
- With Spouse/Partner
- With other family members

Who _____

- Skilled Nursing Facility

Name _____

YOUR MEDICATIO NS

No Medications **List all the medications you take, both prescription & nonprescription below:**

Are you taking Aspirin or any other blood thinners? Yes No

Medication or Brand Nam e	Dose	Medication or Brand Nam e	Dose

YOUR ALLERGIES

No Allergies **Indicate all the allergies you have to medications and/or food & describe the reaction below:**
Common reactions include; Anaphylaxis (life threatening), Hives, Itching, Nausea, Vomiting, Trouble breathing

Pharma cy Nam e:

Pharma cy Phone #:

Street Address:

City/ State/ ZIP

YOUR PAST MEDICAL HISTORY

Disease Type:	Date of Onset:	Disease Type:	Date of Onset:
AIDS/HIV		Kidney Disease	
Alzheimer's		Multiple Sclerosis	
Anxiety		Obesity	
Cancer (type)		Osteoarthritis	
Coronary Disease		Osteoporosis	
Depression		Pacemaker	
Diabetes Type I/Type II		Parkinson's	
DVT/Blood Clots		Peripheral Vascular Disease	
Heart Attack		Stroke	
Heart Disease		Tuberculosis	
Hepatitis		Ulcers	
Hypertension		Other _____	
Irritable Bowel Syndrome		No known medical history	

YOUR PAST SURGICAL HISTORY

Surgery Type:	Year of Surgery:	Surgery Type:	Year of Surgery:
☐ Hip Replacement – RT/LT		☐ Fracture – Type	
☐ Knee Replacement – RT/LT		☐ Pacemaker	
☐ Shoulder/Rotator Cuff – RT/LT		☐ Open Heart/Bypass	
☐ Carpal Tunnel – RT/LT		☐ Spine – Type/Level	
☐ Arthroscopy – RT/LT		☐ No known surgical history	

Any additional surgical information:

YOUR FAMILY HISTORY

☐ **Family History Unknown**

Mother	Father	Sister	Brother
☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis

YOUR SOCIAL HISTORY

TOBACCO USE	ALCOHOL USE	CAFFEINE USE	GENERAL PREVENTATIVE
☐ *Current* ☐ *Former* ☐ *Never* *Packs/Day:* _____ *Years Used:* _____ *Have you ever tried to quit?* ☐ *Yes* ☐ *No* ☐ *I would like information on quitting*	☐ *No* ☐ *Yes* ☐ *Former* *Type:* ☐ *Beer* ☐ *Wine* ☐ *Liquor* *Amount per sitting:* _____ *Last Drink:* _____	☐ *No* ☐ *Yes* *Type:* ☐ *Coffee* ☐ *Tea* ☐ *Soda* ☐ *Tablets* ☐ *Energy Drinks* ☐ *Chocolate* *Daily Amount:* _____	*When was your last* *Bone Density* _____ *Colonoscopy* _____ *Flu Shot* _____ *Mammogram* _____ *Pneumonia Vaccine* _____ *Seat belt use? YES NO*

REVIEW OF SYSTEMS

☐ All Negative Below CHECK IF YOU HAVE ANY OF THE FOLLOWING:

General	Cardiovascular	Metabolic	Skin	Blood Disorders	Psychiatric
☐ Fever	☐ Heart Murmur	☐ Cold Intolerance	☐ Rash	☐ Bleeding	☐ Anxiety
☐ Weakness	☐ Leg Swelling/Edema	☐ Heat Intolerance	☐ Skin Infections	☐ Bruising	☐ Depression
☐ Weight Gain/Loss (circle)	☐ Syncope/Fainting	☐ Insulin Dependent	☐ Skin Lesions		☐ Insomnia
Ears, Nose & Vision	**Gastrointestinal (GI)**	**Neurological**	**Respiratory**	**Urinary**	**Immune System**
☐ Blurred Vision	☐ Constipation	☐ Difficulty Walking	☐ COPD	☐ Dysuria (difficulty urinating)	☐ Asthma
☐ Facial Pain	☐ Diarrhea	☐ Dizziness	☐ Dyspnea (difficulty Breathing)	☐ Frequent Urination	☐ Environmental Allergies
☐ Headache	☐ Nausea/Vomiting	☐ Poor Coordination	☐ Recent Infections	☐ Hematuria (blood in urine)	☐
☐ Vertigo/Dizziness	☐ Reflux	☐ Muscle Weakness	☐ Wheezing	☐ Other (please specify)	
☐ Recent Infections	☐	☐ Insomnia	☐ Food Allergies		

I attest that the information provided above is complete and accurate as it will be utilized as part of my care and treatment plan

Patient or Guardian Signature: _____ Date: _____/_____/_____

ORTHOPEDIC CENTER OF FLORIDA PRIVACY NOTICE PATIENT COPY

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 privacy notice is being provided to you as a requirement of federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information in some cases. Orthopedic Center of Florida is required by law to provide you our Privacy Notice, maintain the privacy of your information, follow the terms of our Privacy Notice and tell you we have the right to change the Privacy Notice.

I. Uses and Disclosures of Protected Health Information

Orthopedic Center of Florida may use your protected health information (PHI) for purposes of providing treatment, and conducting health care operations. "PHI" may be used or disclosed only for these purposes unless Orthopedic Center of Florida has obtained authorization. Disclosure of your protected health information for the purposes described in this Privacy Notice may be in writing, orally, or by facsimile.

a. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your PHI to a pharmacy to fill a prescription or to a laboratory to order a blood test.

b. Payment. Your PHI will be used, as needed, to obtain payment for the services that we provide. For example, we may need to disclose your information to your health insurance company to get prior approval for surgery. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

c. Operations. We may use or disclose your PHI, as necessary, for your own health care operations to facilitate the function of Orthopedic Center of Florida and to provide quality care to all patients.

Health care operations include such activities as: quality assessment and improvement activities.

d. Other Uses and Disclosures. We may also use or disclose your PHI for the following purposes:

such as to remind you of your surgery or to call after surgery to check on your status.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to disclose your PHI without permission or authorization for a number of reasons including the following:

a. When legally required
b. When there are risks to public health
c. To report suspected abuse, neglect or domestic violence
d. In connection with judicial and administrative proceedings
e. For Workers Compensation
f. We may disclose your PHI to your family member or close personal friend if it is directly relevant to the person's involvement in care or payment related to your care

III. Your Rights

a. The right to inspect and obtain a copy of your PHI
b. The right to request a restriction on uses and disclosures of your PHI
c. The right to request amendments to your PHI
d. The right to receive an accounting by Orthopedic Center of Florida of certain disclosures of PHI

IV. Complaints

You have the right to express complaints to Orthopedic Center of Florida and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the Privacy Officer verbally or in writing, using the contact information below.

V. Contact Person

JoAnn Smith, Business Office Manager/Privacy Officer

Acknowledgment of Notice of Privacy Practices

Name of Patient (please print) _____

Date of Birth: _____

I hereby acknowledge that I received **Orthopedic Center of Florida's** Notice of Privacy Practices.

_____

Signature of patient or patient representative Date

Authorization for Disclosure of Health Information

I hereby authorize Orthopedic Center of Florida to release/discuss my Protected Health Information to include but not limited to billing, treatment, test results etc., with the following individuals:

_____	_____	_____
NAME	DOB	RELATIONSHIP
_____	_____	_____
NAME	DOB	RELATIONSHIP
_____	_____	_____
NAME	DOB	RELATIONSHIP

This authorization will remain in effect until such time as I submit a change in writing.

_____

Signature of patient or patient representative Date

Credit, Payment Assignment and Release Policy & Consent

PATIENT COPY

We are pleased that you have chosen Orthopedic Center of Florida for your medical care. Our goal is to provide you with the highest level of professional medical care possible, while keeping medical costs reasonable. In an effort to provide quality medical services, we have established the following credit and payment policies.

If You Do Not Have Insurance Coverage

We accept cash, debit, personal check, money order, American Express VISA, Discover, and MasterCard payments.

If You Do Have Insurance Coverage

We will submit claims on your behalf to your primary and secondary insurance carriers. When insurance information is unavailable or invalid insurance is provided at the time of service, the patient or their legal guardian is responsible for all charges incurred. Your insurance contract is between you and your carrier. Any remaining patient balance after your insurance carrier(s) has made payment is due immediately upon receipt of your Orthopedic Center of Florida account statement. Patients or their legal guardian are required to bring a photo ID, their current insurance identification card(s) and the applicable co-payment, coinsurance and deductible to each appointment.

It is your responsibility to obtain the appropriate authorization if it is required for your visit. OCF will help you in your request for an authorization from your primary care physician or PCP. If you have questions or concerns about your insurance coverage, please call your carrier. It is the responsibility of each patient or their legal guardian to understand the terms and conditions of their insurance plan(s).

Missed and Cancelled Appointments

Our Clinics request that you notify us 24 hours in advance when canceling a scheduled appointment. This allows other patients with medical needs to be seen. We reserve the right to charge a fee of $25 for any appointment missed or cancelled without reasonable notice.

Financial Responsibility

Patients or their legal guardian are financially responsible for all services received. If you do not pay your co-payment at the time of service, a $25 billing fee may be charged. Overdue accounts are subject to a rebilling fee of $10 per month and may be placed on a cash payment basis for future appointments. If you are required to pay for treatment at the time of service, but are unable to do so, your appointment may be rescheduled. A $25 fee will be assessed for any check returned by your bank for any reason. Failure to meet your financial responsibility may result in collection or legal actions. Accounts that are turned over to a collection agency may be assessed a collection account fee of 10% of the outstanding balance.

Care Credit

Please contact our billing department to apply for a Care Credit Card or www.carecredit.com

Acknowledgement of Credit, Payment Assignment and Release Policy

I request that payment of benefits be made on my behalf to Orthopedic Center of Florida, for any services furnished to me. I authorize release of medical information to my insurance carrier if it is needed to determine benefits payable.

To Our Medicare Patients: I request that payment of authorized benefits be made on my behalf to Orthopedic Center of Florida for any services furnished to me by the physician(s). I hereby authorize Orthopedic Center of Florida/any holder of medical information about me to be released to the Healthcare Financing Administration or its intermediaries/agents. This authorization can only be revoked in writing.

I understand that I am responsible for any deductible, co-insurance, or non-covered services. The undersigned hereby obligates him/her to pay the account for the medical services rendered.

By signing this form, I acknowledge that I have read and understood the Credit and Payment Policy & Consent of Orthopedic Center of Florida.

_____

Signature of patient or patient representative Date

CONTROLLED SUBSTANCE (NARCOTIC) AGREEMENT *(Patient Copy)*

The purpose of this consent is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opiates (narcotic analgesics), benzodiazepine tranquilizers, and other sedatives are controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder (psychological dependence/physical dependence) developing or of relapse occurring in a person with a prior addiction. The percent of this risk is not certain.

Because these drugs have the potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, any condition, the willingness of the physician and/or physician assistant whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

GENERAL

1. All controlled substances must come from the physician and/or physician assistant who's initial appears below or, during his or absence, by the covering physician or physician assistant unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment).

2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies our office must be informed in writing.

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

4. The use of medications is not designed to completely eliminate the pain, rather the medication is used to significant reduce pain so that the individual may be able to perform many activities of daily living as well as social activities. It is hoped that the use of these medications will improve the quality of life but is not expected that the pain relief will be complete.

5. You may not share, sell, trade, exchange your medications for money, goods, services, etc. or otherwise permit others to have access to these medications. You agree to keep these medications in a secure place.

6. You, the patient, may be subject to voluntary evaluation by psychologists or psychiatrists (at the patient's expense if necessary) before treatment and this will be reevaluated every 3-6 months thereafter while being maintained with opioid/pain therapy.

7. Since the drugs may be hazardous or lethal to a person that is not tolerant to its affects, especially a child, you must keep them out of the reach of such people.

8. Prescriptions and bottles of these medications may be sought by individuals with chemical dependency and should be closely safeguarded. It is expected that your will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

9. It may be requested by an OCF provider that original containers of medications be brought into the office at each visit to document compliance and to prevent overuse.

10. I will not attempt to get pain medications from any other health care provider without telling them that I am taking pain medications prescribed by the OCF providers.

11. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care.

12. Unannounced, random urine or serum toxicology screens may be requested by OCF provider to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder. **Refusal of such testing may subject you to an abrupt rapid wean schedule in order for the medication to be discontinued or prompt termination from care**.

13. I realize that is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by OCF.

14. I will not use any illegal substances (cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of care at OCF effective immediately.

15. I will not alter my medication in any way (for example crushing or chewing tablets) or use any other auto-delivery (for example injection on insufflation) other then as prescribed by OCF.

16. Long-term agents (MSContin, OxyContin, Oramorph, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected, and snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which often times may lead to death.

17. I understand that changing date, quantity or strength of medications or altering a prescription in any way, shape or form is against the law. Forged prescriptions or the provider's signature is also against the law. OCF cooperates fully with law enforcement agencies locally as well as the Drug Enforcement Agency (DEA) in regards to infractions involving prescription medications. If there is a law violation this will be reported to the patient's pharmacy, local authorities and DEA.

18. I will discontinue all previously used pain medications, unless told to continue them by OCF. I will keep OCF informed of all medications I may receive from other physicians. This includes the emergency department at hospitals if being treated. You the patient also agree to inform other treating physicians that you are under controlled substance agreement at OCF.

19. I understand that strong medications, which may include opiates and other controlled substances may be described for pain relief. I understand that there are potential risks and side effects with taking any medications, including the risks of addiction. Overdose of opiate medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opiate pain killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.

20. I realize that all medications have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long-term use of substances prescribed.

21. It should be understood that any medical treatment is initially a trial, in that a continued prescription is contingent on evidence of benefit.

22. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

23. I will keep all scheduled appointments in the OCF clinic. Three or more cancellations with less than hours' notice can result in a termination of my treatment by OCF.

24. **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal.

25. **(Females only)** If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and/or primary care provider and the OCF office to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I am aware that the u se of opioids is not generally associated with the risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking opioids.

    The child could be physically dependent on the opiates and withdrawal can be life threatening for a baby. If a female of child-bearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with medications from OCF.

REFILLS

1. **Prescriptions <u>will not</u> be phoned in after hours, on weekends or holidays. No exceptions.**

2. Timely request for refills of medications are solely the patient's responsibility. You agree to adhere to the OCF prescription pick-up policy.

3. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with an OCF prescriber/physician.

4. The prescribing provider will be the only one to decide when and how the patient is to increase or decrease various pain medications. If the provider decides to discontinue the use of pain medicine, the provider will follow the patient through a tapering off.

5. Early refills will not be given. The patient is responsible for taking the medications as prescribed. No unauthorized increase in medications will be tolerated.

6. Refills will not be made as an "emergency". There is a 4 day minimal request to request medication/prescription refills (please see OCF prescription policy).

7. Changes in prescriptions/refills will be made only during scheduled appointments and not via phone, at night, on weekends or holidays. This policy will be strictly adhered to.

8. The patient will sign off on "Prescription Policy" for any prescriptions picked-up from office. This will inform patient of any recent changes regarding OCF prescriptions/policies.

9. Renewals are contingent upon keeping scheduled appointments and following the OCF prescription policy.

10. I agree that continued refill of medications may be contingent upon compliance with other chronic pain treatment modalities recommended by my doctor/physician assistant and with the program in general.

11. Refills will not be made if "I ran out early" or "I lost my prescription" or "spilled, damaged, misplaced, stolen medication". The patient is responsible for taking the medications in the dose prescribed and for keeping track of the amount remaining.

12. Medications will not be replaced if they are lost, misplaced, or destroyed, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made at the discretion of the OCF prescriber/provider. However, there is a fee for prescription replacement. (Please refer to our "Administrative Fee Schedule Sheet")

13. Prescriptions may be issued earlier if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist regarding when prescription(s) is allowed to be refilled.

14. If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived and these authorities may be given full access to our records of control substances administration. (For example, you are obtaining medications from other physicians and/or pharmacies)

15. I understand that I must contact an OCF prescriber/provider before taking tranquilizers or prescription sleeping medications. I understand that the combined use of the various drugs, opiates as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease and even death.

16. I understand that one my pain management is optimized, refill of my medications may be transferred to my primary care physician. If I do not have a primary care physician at that time I will have from 1-3 months to find a physician who will take over my care and prescribe my medications.

17. I understand that my medication regimen may be continued for definitive time, as determined by my OCF providers. My case may be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my function and quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

WITHDRAWAL SYNDROME / TOLERANCE

1. These drugs should not be stopped abruptly, as an abstinence syndrome ("withdrawal syndrome") will likely develop.

2. I understand that opiate analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms which may occur in 24-48 hours of last dose of opioid therapy. Typically this will last a few days. The withdrawal symptoms are usually self-limited but could in rare cases be life threatening.

3. Potential symptoms: yawning, nausea, vomiting, watery eyes/nose, abdominal cramps, diarrhea, muscle or body aches, sweats, chills, hot/cold flashes, "goose flesh", anxiety, agitation, irritability, insomnia, tremors, "racing heart" (increased or decreased heart rate), sweating, watery eyes, runny nose, anxiety, tremors, achy muscles, hot or cold flashes, craving for the medication.

4. Withdrawal from other medications can also have serious consequences, including the risk of injury or death. I will not discontinue any medication I take regularly without consulting an OCF provider or my primary care provider.

5. Tolerance is a condition which can occur with the use of opioid medications. It is defined as a need for a higher opioid dose to maintain the same pain control. Usually tolerance to sedation, euphoria, nausea and vomiting occurs more commonly then tolerance to pain relief. This condition may be controlled by switching to a different opioid medication. Tolerance can also be managed by adding a second different drug to the opioid management. If tolerance to the opioid becomes unmanageable the opioid will be tapered and discontinued. The patient must report significant side effects to each of the medications. For example: over sedation, nausea, vomiting, constipation, confusion, euphoria (high feeling) and dysphoria (down feeling), dizziness, sweating, respiratory depression (slow breathing), stomach upset, quick-sudden-jerky movements of the arms or legs, headaches, weakness, tremors, seizures, dreams, muscular stiffness, hallucinations, disorientation, visual disturbances, insomnia, dry mouth, diarrhea, stomach cramps, taste alteration, flushing of the face, chills, increase or decrease in heart rate, increase or decrease in blood pressure, difficulty in urination, itching, skin rashes, swelling with the skin, irritation, irritability, and sexual dysfunction.

6. It is clearly understood that the use of narcotic medication may result in physical dependence. This condition is common to many drugs including steroids, blood pressure medications, anti-anxiety medications, anti-seizure medications as well as opioids. Physical addiction poses no problem to the individual or to the prescribing provider as long as the individual avoids abrupt continuation of the medication. Medication can be safely discontinued after 2-3 weeks of a slow taper. Treatment of intractable chronic pain problems with the use of opioids is controversial. It is however endorsed by many specialists in the field for pain problems, not treatable my any other methods.

7. Treatment of pain problems with this method is nearly always accomplished by using the “analgesic ladder” (using less potent pain medications first and adding to these, other adjutant medications to achieve a combined affect). Psychological addition should also be understood as a possible risk to the use of opioid medications. This has been shown to be an infrequent occurrence in patients who have been diagnosed with an organic disease causing chronic pain.

8. Psychological addiction is recognized when the individual abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or “doctor shopping”, when the drug is quickly escalated without correlation with the pain relief or when the patient shows a manipulative attitude toward the physician/provider in order to obtain the drug. If the individual exhibits such behavior, the drug will be tapered and the individual will not be a candidate for continued treatment.

COMPLIANCE

1. I understand that phone calls after hours should be for issues such as post procedure, post-surgical complications, significant medication side effects and other urgent matters. For the true medical emergency, “911” should be called and/or emergency department treatment should be sought. For non-emergency matters the clinic should be called during normal business hours. There may be a fee assessment for non-emergent calls being placed outside of the routine clinic hours. This is not billable to your insurance.

2. I understand that the main treatment goal is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor. I understand that through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

3. I agree to fully comply with all aspects of my treatment program, including behavioral, medicine and physical therapy. Failure to do so may lead to discontinuation of my medication and discontinuation from the pain program.

4. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medications and authorize the physicians, my pharmacy and insurers to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion/inappropriate use of my pain medication. I authorize OCF to provide a copy of this agreement to my pharmacy, other health care providers, insurance carrier and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies/facilities.

5. My Orthopedic Center of Florida (OCF) physician/physician assistant agree that this agreement is important to my providers ability to treat my pain effectively and my failure to comply with the agreement may result in the discontinuation of prescribed medications by my provider and termination of the physician/provider/patient relationship.

6. I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by the OCF prescribing provider. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the OCF medication management program. I also agree to random testing and detoxification if further indicated.

7. It is understood that failure to adhere to these policies may result in cessation of therapy with control substance prescribed by this physician/physician assistant or referrals for further specialty assessment.

8. You are informed that you have the right and power to sign and be bound by this agreement, and that you have read, understand and except all of its terms.

The OCF physicians/physician assistants understand that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by OCF in no way invalidates any other provisions of this agreement.

Acknowledgment of Controlled Substance (Narcotic) Agreement

I have read this form or have had it read to me. I have received a copy of the Controlled Substance (Narcotic) Agreement. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily. I am aware of the many potential risks versus benefits.

Patient Signature: _____ Date: _____

Witness to Above: _____

Prescribing Provider: _____

If at any time you are concerned about your medications or side effects of your medication you may call OCF at 239-482-2663. The on-call physician or physician assistant can also be contacted to receive your message if necessary.

I agree to use _____ pharmacy for all my pain medications.

Located at: _____

_____

_____

Phone #: ( ) _____-_____ Fax #: ( ) _____-_____

If I change my pharmacy for any reason, I agree to notify OCF (in writing) at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacies address and phone number.

This agreement is entered into on this _____ day of _____, 20_____

Patient Name: _____ Date of Birth: _____/_____/_____

(Please print)_____

Soc. Sec. #: _____-_____-_____

Patient Signature: _____ Date: _____/_____/_____

Prescribing Provider: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

CONSENT FOR CHRONIC OPIOID THERAPY *(Patient Copy)*

OCF may prescribe opioid medication, sometimes called narcotic analgesics which may be controlled substances as deemed appropriate by my treating provider.

The decision was made because by condition is serious or other treatments have not helped my pain.

I am aware that use of such medication has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing, slowing of reflexes or reaction time, physical dependence, tolerance to analgesic, addiction and possibility that the medication will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. Multiple modalities have been considered including but not limited to physical therapies, anti-inflammatories, ice, heat, home exercise programs, chiropractic care and physician evaluation.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or not thinking clearly. I am aware that even if I do not notice it my reflexes and reaction time might still me slowed. Such activities include but are not limited to: using heavy equipment or motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself. I am aware that certain other medications such as nalbuphine (newbain), pentazocine (tallwin), buprenorphine (buprenex), and butorphanol (stadol) may reverse the action of the medication I am using for pain control. Taking any of these other medications while I am taking my pain medication can cause symptoms like a bad flu, cold withdrawal symptoms. I agree not to take any of these medications and to tell any other physicians that I am taking an opioid as my pain medication and cannot take any of these pain medications listed above. I am aware that addiction is defined as the use of medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my prescribing provider my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, “goose bumps”, abdominal pain or cramping, diarrhea, irritability, muscle aches, decrease or increase heart rate, agitation, insomnia, hot or cold hot flashes. This will occur throughout my body and this is a flu like feeling. I am aware that opiate withdrawal is uncomfortable and typically not life threatening. However, this is dependent on other health issues/concerns.

I am aware that tolerance to analgesics means that I may require more medications to get the same amount of pain relief. I am aware that tolerance to analgesics does not seem to be a big problem from most patients with chronic pain, however it has been seen and may occur in me. If it occurs increasing doses may not always help and may cause intractable side effects. Tolerance or failure to respond well to opioids may cause my prescribing provider to choose another form of treatment.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician my check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I am have become pregnant while taking this medication, I will immediately call my obstetric doctor and/or primary care provider and the OCF office to inform them. I am aware that, should I care a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with the risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking opioids.

Acknowledgment of Consent for Chronic Opioid Therapy Agreement

I have read this form or have had it read to me. I have received a copy of the Consent for Chronic Opioid Therapy. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily. I give my consent for the treatment for my pain with opioid pain medicines. I am aware of the many potential risks versus benefits.

Patient Signature: _____ Date: _____

Witness to Above: _____

Prescribing Provider: _____