We want to thank you for becoming a patient at Medstar Health Solutions. We want to take this opportunity to emphasize specific Tennessee State and Clinical Guidelines for pain management patients that will **not be tolerated** at this facility. Under the direction of our Medical Director the following actions are forbidden and will lead to immediate discharge:

- Illicit Drug Use / Excessive Alcohol Use
- Falsifying a UDS
- Trying to intentionally pass off the wrong medication for a pill count
- Suicide attempt within the past 12 months
- Drug-Related charges/convictions
- Track marks
- Belligerent behavior toward Nurse Practitioners or office staff
- Patient refusal to obtain a primary care provider after the allowable 90 day period given to obtain a primary care provider has expired
- Anyone started on Suboxone for treatment of addiction

Please take the time to review **ALL** state and clinical guidelines that are outlined in your contract with Medstar Health Solutions.

Thank you Management

Patient Info Sheet - Please Print

Name: _____ Date of Birth: _____

Address: _____Sex: ❑M or ❑F Age: _____

_____ Marital Status: ❑S ❑M ❑D ❑W ❑Sep.

City: _____ State: ____ Zip: _____ SS#: _____

Home Phone: _____Cell Phone: _____

Drivers License Number: _____ State: _____ Exp. Date: _____

Emergency Contact Information:

Name: _____ Phone: _____

Name: _____Phone: _____

Payment

I, _____ , agree to the payment terms set forth by Medstar Health Solutions and acknowledge that I will be responsible for any fees and charges related to my care that are deemed necessary by the physician.

I understand that Medstar Health Solutions does not file insurance. This clinic outsources all lab and imaging, therefore, a copy of your insurance card may be requested.

I agree that I will be responsible for payment in full at the time services are rendered.

Patient Signature: _____ Date: _____

Authorization to Release Medical Information

Patient: _____Date of Birth: _____Phone: _____

Request to release confidential medical information from: Facility Name_____
Facility Phone_____
Facility Fax_____

Specific Type of Information To Be Released:
❑ Complete Medical Records ❑ All Imaging results ❑ Lab Reports ❑ RX History ❑ Last 3 office notes

For Date Range: _____ to _____
(If no time period specified, records from previous 5 years only will be released)

Purpose of Disclosure:
❑ Transfer of Care ❑ Disability ❑ Pain Management ❑ Social Security ❑ Attorney Request ❑ Other

RELEASE MEDICAL RECORDS TO:
Medstar Health Solutions, PLLC
3915 Bristol Hwy Suite 402
Johnson City, TN 37601
(p)423-491-5500 (f)423-979-7100

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire after one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at the disclosure location.

Signature of Patient or Legal Representative: _____Date Signed:_____
If Signed by a Legal Representative, Relationship to Patient: _____
Signature of Witness: _____

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian:

_____

Signature: _____Date: _____

Practice Use Only

I attempted to obtain the patients signature in acknowledgment of the Notice of Privacy Practices but was unable to do so as documented below:

Date: _____Initials: _____

Reason:

_____

_____

_____

_____

HIPAA Consent Form - Health Insurance Portability and Accountability Act

Patient Name: _____

Date of Birth: _____

In connection with the medical services that I receive from the above named physician, I hereby authorize Medstar Health Solutions to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

- Any third party payor covering the medical services received
- Other health care professionals and institutions involved in the delivery of health care to me, the patient
- The proponent of any legal sufficient subpoena or court order
- Employees/Contractors of the provider, to facilitate the necessary provision of health care services and payment for such services
- Pharmacies
- Other parties required by law

In each case the practice shall take legal steps to insure that only the necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place any restrictions upon the consent hereby given:

Please list the names/relationships of anyone you wish you authorize Medstar Health Solutions to speak with regarding your medical care and condition:

Name: Relationship:

_____ _____

_____ _____

_____ _____

Medstar Health Solutions may leave a message on or with:

- ❑ Voicemail
- ❑ Employer
- ❑ Cell Phone

This consent is valid from the date executed until revoked in writing by the patient or verbal consent and witnessed.

Patient Signature: _____

Date: _____ Witness: _____

NEW PATIENT QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Current Age: _____

Primary Care Provider: _____ Phone Number: _____
When was your **LAST** visit to your Primary Care Provider? _____

Neurosurgeon/Orthopedist: _____ Phone Number: _____
Neurologist: _____ Phone Number: _____

PREVIOUS pain clinic(s)/provider(s) treating your pain:
_____
_____
_____

Have you **EVER** been discharged from another pain clinic/pain provider? Yes No
If yes, please provide details: _____

Have you **EVER** been charged with or convicted of a drug-related crime? Yes No
If yes, please provide details: _____

Where is your pain located? _____
When did your pain begin? _____
What caused your pain? _____

CURRENT level of pain: (Circle **ONLY** one)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Level of **WORST PAIN** in the past **24 HOURS:** (Circle **ONLY** one)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

LOWEST level of pain in the **PAST 24 HOURS:** (Circle **ONLY** one)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Does your pain interfere with your mood? Yes No
Does your pain interfere with your ability to walk? Yes No
Does your pain interfere with your ability to perform general daily activities? Yes No
Does your pain interfere with your ability to perform your job duties at work? Yes No
Does your pain interfere with your enjoyment of life? Yes No
Does your pain interfere with your ability to sleep? Yes No

My **OVERALL** sleep is? Poor Fair Good Excellent

Please **DESCRIBE** your pain: (Circle **ALL** that apply)

Constant Intermittent Aching Dull Sharp Stabbing
Throbbing Shooting Burning Excruciating Intolerable Numbness
Tingling Pins/needles
Other (please list): _____

What **IMPROVES** your pain? (Circle **ALL** that apply)

Rest Sitting Standing Lying down Alternating positions
Walking Exercise Stretching Heat Ice TENS
Wearing a brace Medications Other (please list): _____

What **WORSENS** your pain? (Circle **ALL** that apply)

Sitting Standing Lying down Bending Walking Lifting objects
Exercise Other (please list): _____

In the **PAST 30 DAYS**, how much relief have your pain medications and/or treatments provided?

(None) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (Complete Relief)

Have you **EVER** tried any of the following treatment modalities for your pain? (Check **ALL** that apply)

___ Proper Diet ___ Helpful ___ Not Helpful Adverse Effects _____
___Exercise ___ Helpful ___ Not Helpful Adverse Effects _____
___ Physical Therapy ___ Helpful ___Not Helpful Adverse Effects _____
___Massage Therapy ___ Helpful ___ Not Helpful Adverse Effects _____
___Chiropractic ___ Helpful ___ Not Helpful Adverse Effects _____
___Acupuncture ___ Helpful ___ Not Helpful Adverse Effects _____
___Traction ___ Helpful ___ Not Helpful Adverse Effects _____
___TENS ___ Helpful ___ Not Helpful Adverse Effects _____
___Wearing a Brace ___ Helpful ___ Not Helpful Adverse Effects _____
___Joint Injections ___ Helpful ___ Not Helpful Adverse Effects _____
___Spinal Injections ___ Helpful ___ Not Helpful Adverse Effects _____
___Infusion Therapy ___ Helpful ___ Not Helpful Adverse Effects _____
___Radiofrequency ___ Helpful ___ Not Helpful Adverse Effects _____
___ Spinal Cord Stimulator ___ Helpful ___ Not Helpful Adverse Effects_____
___ Other ___ Helpful ___ Not Helpful Adverse Effects _____

PAST MEDICAL HISTORY: (Please check **ALL** that apply)

___ Asthma ___ Sleep Apnea Do you use CPAP or BiPAP? Yes No
___ COPD/Emphysema Do you use home oxygen? Yes NO If yes, how many liters? _____
___ Diabetes ___ Diabetic Neuropathy ___ Other Peripheral Neuropathy (Cause?)_____
___ HIV/AIDS ___ Hepatitis Type? _____ ___ Cirrhosis ___ GERD (Reflux)
___ High Blood Pressure ___ High cholesterol ___ Osteoporosis ___ Shingles
___ Hyperthyroidism (overactive thyroid) ___Hypothyroidism (underactive thyroid) ___ Osteoarthritis
___ Peripheral Vascular Disease ___ Kidney Disease Are you on dialysis? Yes No

___ Stroke (list residual deficits/weakness) _____
___ Heart Disease (congestive heart failure/heart attack/other - please give details) _____
_____
___ Pulmonary Embolism (blood clot in lungs) ___ Deep Venous Thrombosis (blood clot in arms/legs)
___ Seizures/Epilepsy (please give details) _____
___ Cancer (please give type/location/treatment) _____
___ Other (please give details) _____

PSYCHIATRIC/MENTAL HEALTH HISTORY: (Please check **ALL** that apply)
___ Depression ___ Bipolar Disorder ___ Post-Traumatic Stress Disorder
___ Schizophrenia ___ Anxiety ___ Attention Deficit Disorder
___ Suicide attempt(s) (If so, provide details): _____
___ Psychiatric hospitalizations (If so, provide details): _____
Have you **EVER** been treated by a Psychiatrist/mental health provider: Yes No
Psychiatrist/mental health provider: _____ Phone Number: _____

PLEASE LIST ALL PREVIOUS SURGERIES:
_____ _____
_____ _____
_____ _____
Do you have **ANY** metal implants or metal fragments in your body (example – pacemaker)? Yes No
If yes, please provide details: _____

FAMILY HISTORY:
___ Alcohol Abuse ___ Drug Abuse ___ Depression ___ Suicide/Suicide Attempt
___ Cancer ___ Heart Disease ___ Diabetes ___ High Blood Pressure
___ Stroke ___ Other (please list): _____

SOCIAL HISTORY:
Do you smoke? ___ Never Smoked ___ Former Smoker When did you quit? _____
Current Smoker ___ How many packs per day? _____ When did you start? _____

Do you drink alcohol? Yes No If yes, how many drinks per day? _____
How long have you been drinking alcohol? _____
Have you **EVER** been hospitalized for alcohol abuse, or do you **CURRENTLY** have or have you **EVER** had a problem with alcohol abuse? Yes No
If yes, please provide details: _____
Have you **EVER** been in or are you **CURRENTLY** in a treatment program for alcohol abuse? Yes No
If yes, please provide details: _____

Have you used **ANY** of the following drugs in the **PAST 12 MONTHS:** (Check **ALL** that apply)
___ Heroin ___ Cocaine ___ Ecstasy ___ Methamphetamines ___ Marijuana
___ Other ___ Another Person's Prescription Medications
___ I have **NEVER** used illicit drugs or taken prescription drugs illegally

If yes, please explain most recent use of **ALL** that apply: _____
Have you **EVER** had a drug overdose, whether intentional or unintentional? Yes No
Is yes, please provide details: _____
Have you **EVER** been hospitalized for drug addiction, or do you **CURRENTLY** have or have you **EVER** had a problem with drug addiction, whether illicit drugs or prescription medications? Yes No
If yes, please provide details: _____
Have you **EVER** been in or are you **CURRENTLY** in a drug treatment program? Yes No
If yes, please provide details: _____

Have you taken Suboxone (buprenorphine) for drug addiction in the **PAST 12 MONTHS**? Yes No
If so, please provide details: _____

What is your marital status?
___ Married ___ Divorced ___ Single ___ Divorced/Remarried ___ Separated ___ Widowed

What is your highest level of education? _____

What is your work status?
___ Unemployed ___ Disabled ___ Employed Full-Time ___ Employed Part-Time
___ Homemaker ___ Retired What is/was your occupation? _____

Do you have **ANY** medication allergies? Yes No
If yes, please list **ALL** medication allergies below:

Medication	Allergic Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list **ALL** current medications, including prescription and/or over-the-counter medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please mark **ALL** medications previously tried for pain:

Gabapentin (Neurontin)
__ Helped __ Did not help Reason for discontinued use _____
Lyrica
__ Helped __ Did not help Reason for discontinued use _____
Tramadol (Ultram)
__ Helped __ Did not help Reason for discontinued use _____
Hydrocodone (Lortab/Lorcet/Norco/Vicodin/Hysingla/Zohydro)
__ Helped __ Did not help Reason for discontinued use _____
Percocet (Endocet/Roxicet)
__ Helped __ Did not help Reason for discontinued use _____
Oxycodone (Roxicodone)
__ Helped __ Did not help Reason for discontinued use _____
OxyContin
__ Helped __ Did not help Reason for discontinued use _____
Oxymorphone (Opana)
__ Helped __ Did not help Reason for discontinued use _____
Nucynta (Tapentadol)
__ Helped __ Did not help Reason for discontinued use _____
Morphine (MS Contin/Embeda/Kadian/Avinza)
__ Helped __ Did not help Reason for discontinued use _____
Fentanyl (Duragesic)
__ Helped __ Did not help Reason for discontinued use _____
Hydromorphone (Dilaudid/Exalgo)
__ Helped __ Did not help Reason for discontinued use _____
Methadone (Dolophine)
__ Helped __ Did not help Reason for discontinued use _____
Butrans patch (buprenorphine transdermal)
__ Helped __ Did not help Reason for discontinued use _____
Suboxone (buprenorphine/Subutex)
__ Helped __ Did not help Reason for discontinued use _____
Other not listed above

_____ _____
_____ _____
_____ _____
_____ _____

Of those listed below, please check **ALL** symptoms you have experienced in the **PAST 30 DAYS:**

Constitutional:
___ Sudden weight loss ___ Sudden weight gain ___ Fever ___ Chills ___ Excessive fatigue
Skin:
___ Rash ___Skin changes ___ Itching
Hematologic/Lymphatic:
___ Easy bruising ___ Easy bleeding ___ Swollen glands
Head, Eyes, Ears, Nose, Throat:
___ Frequent headaches ___ Severe headaches ___ Vision loss ___ Blurred vision
___ Double vision ___ Hearing loss ___Ringing in ears ___ Nosebleeds ___ Hoarseness
___ Trouble swallowing
Cardiac:
___ Chest pain ___ Rapid heart-beat ___ Irregular heart-beat ___ Excessive sweating
___ Swelling in legs/feet ___ Lightheadedness
Respiratory:
___ Shortness of breath ___ Persistent cough ___ Wheezing ___ Coughing up blood
Gastrointestinal:
___ Abdominal pain ___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation
___ Blood in stool ___ Loss of bowel control ___ Loss of appetite
___ Change in bowel movements
Urinary:
___ Painful urination ___ Blood in urine ___ Frequent urination ___ Difficulty urinating
Reproductive:
___ Sexual dysfunction ___ Painful sex
Endocrine:
___ Excessive thirst ___ Increased urination ___ Heat intolerance ___ Cold intolerance
Musculoskeletal:
___ Joint pain ___ Back pain ___ Neck pain ___ Joint swelling ___ Joint stiffness
___ Morning stiffness ___ Muscle pain/tenderness ___ Muscle cramps
Neurologic:
___ Trouble with memory ___ Changes in speech ___ Tremors ___ Poor coordination
___ Muscle weakness ___ Loss of muscle mass (size) ___ Numbness ___ Tingling
___ Gait disturbance
Psychiatric:
___ Anxiety ___ Depression ___ Suicidal thoughts ___ Suicide attempts

Beck's Depression Inventory

1.

0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

Print Patient Name:_____

Patient Signature:_____Date:_____

DO NOT COMPLETE, FOR OFFICE USE ONLY

Total Score:_____
Provider Signature:_____Date:_____

SOAPP

Name:_____ Date:_____

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 any of your family members, including your parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4

4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4

5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4

6. How often have you attended an AA or NA meeting? 0 1 2 3 4

7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4

9. How often have your medications been lost or stolen? 0 1 2 3 4

10. How often have others expressed concern over your use of medications? 0 1 2 3 4

11. How often have you felt a craving for medication? 0 1 2 3 4

12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Sign Name:_____ Date:_____

DO NOT COMPLETE, FOR OFFICE USE ONLY
Total Score:_____
Provider Signature:_____Date:_____

OPIOID RISK TOOL PATIENT FORM

Patient's Name:_____ Date:_____

Age:_____

		Mark Each Box That Applies	Score if Female	Score if Male
1. Family History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	☐ ☐ ☐	1 2 4	3 3 4
2. Personal History of Substance Abuse	• Alcohol • Illegal Drugs • Prescription Drugs	☐ ☐ ☐	3 4 5	3 4 5
3. Age (Mark Box if 16-45 years)		☐	1	1
4. History of Preadolescence Sexual Abuse		☐	3	0
5. Psychological Disease	• Attention-Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia • Depression	☐ ☐	2 1	2 1

Do not complete for Office Use Only

Total Score _____Risk Category_____

Low Risk 0-3

Moderate Risk 4-7

High Risk >7

Pain Management Agreement

I, _____ understand that I have entered into a treatment relationship with the nurse practitioners, staff, and clinic medical director of Medstar Health Solutions. This contract is valid throughout the duration of my care at Medstar Health Solutions. I further understand that part of my treatment may include the use of **OPIOID** pain medications and/or **OTHER CONTROLLED SUBSTANCES**.

In order to use these medications safely, I understand that I must consider some of the potential risks of these medications:

- Potential **ADVERSE EFFECTS** include, but are not limited to, sleepiness/drowsiness, nausea, vomiting, constipation, rash, hives, itching, dizziness, difficulty breathing or decreased rate of breathing, decreased reaction time, diminished reflexes, physical dependence, tolerance to analgesia, and/or addiction to opioids. Chronic opioid use (greater than 3 months) can also alter the function of hormones such as progesterone and estrogen in women, and testosterone in men, among other potential hormonal alterations.
- Please inform your provider if you do **NOT** have a bowel movement at least every other day. Constipation must be pro-actively treated. If not, complications may arise.
- Combining anti-anxiety medications and/or sleep medications (example – benzodiazepines such as Xanax) with opioids must be done with **EXTREME** caution, as this can lead to severe respiratory depression and death.
- Combining alcoholic beverages with opioids can also be **VERY** dangerous, and should be **AVOIDED**. This too can lead to respiratory depression and death.
- Taking opioids more frequently than prescribed can also lead to respiratory depression and death. This should be also **AVOIDED**.
- **(WOMEN ONLY)** Opioids can cause **CONSIDERABLE** problems during pregnancy and/or the immediate/early post-partum period (upon delivery and/or soon after delivery). All women of child-bearing age and/or with the potential to become pregnant **MUST** be on birth control during opioid therapy.

In the immediate/early post-partum period, the baby **WILL BE** physically dependent on opioids, and will have a **HIGH** risk of developing **NEONATAL ABSTINENCE SYNDROME**, which can be quite problematic for a newborn. Therefore, you **MUST** immediately notify your provider if you are pregnant or plan to become pregnant.

Our goal is to **REDUCE** your pain level by **AT LEAST 30%,** and to significantly improve your quality of life and your ability to function. This goal will be attained by using multiple treatment modalities, **NOT** just opioid pain medications.

As a patient at Medstar Health Solutions, I **AGREE** to the following **GUIDELINES:**

- I will take **ALL** medications at the dose and frequency prescribed. I will **NOT** change how I take my medications without **PRIOR** approval from my provider at this clinic.
- I **AGREE** to undergo a pill count at **EVERY** visit, and I understand that I may be called in for an unannounced pill count at any time, at the discretion of the providers of this clinic. I understand that I may be **DISCHARGED** should I fail to show-up for a pill count.
- I will bring **ALL** medications prescribed by Medstar Health Solutions, in their **ORIGINAL** pill bottles, to **EVERY** visit and for **EVERY** requested pill count. I understand that I may be **DISCHARGED** for a failed pill count.
- I will arrange refills at the prescribed intervals **ONLY** during regular office hours. I will **NOT** ask for refills earlier than agreed, after hours, on holidays or on weekends.
- I will **NOT** obtain opioids and/or controlled substances from **ANY** other medical provider, friend or family member. Very **FEW** exceptions apply, as detailed below.
- In the event of a planned procedure (example – surgery) which may require a prescription for an opioid and/or other controlled substance from another provider, I **MUST** obtain approval from my provider at this clinic **PRIOR** to accepting and/or filling an outside prescription. Obtaining a prescription for one of these medications from an outside provider, for illegitimate reasons, may result in **DISCHARGE** from the clinic.
- In the event of an emergency, requiring treatment with opioids and/or controlled substances from another provider (example – urgent care, emergency room,

hospital), I will inform my provider at this clinic **AS SOON AS** we open on the next business day. **NOTE:** Not all reasons for obtaining these medications from another provider will be considered acceptable. This **MUST ONLY** occur in the event of a true medical emergency.

- I will **NOT** share my medications with others, trade or sell my medications.
- I understand that if opioids and/or other controlled substances are prescribed to me by this clinic, I will be required to come to the clinic for **MONTHLY** follow-up appointments.
- I will obtain refills **ONLY** at the following pharmacy with full consent for my provider and pharmacist to exchange information in writing or verbally. If this pharmacy does not have my medication, I will use another pharmacy **ONLY** with the **APPROVAL** and **PRIOR** notification of my provider at this clinic.

Name of Pharmacy: _____ Phone number: _____

- I will inform my other healthcare providers that I am taking these medications and of the existence of this agreement. In case of an emergency, I will provide this same information to urgent care, emergency room and/or hospital providers.
- I will protect/secure my prescriptions and medications. I understand that lost or misplaced prescriptions will **NOT** be replaced. Police reports for stolen prescriptions or medications will **NOT** be accepted.
- I will keep **ALL** medications away from children.
- I will **NOT** use illegal substances such as marijuana, cocaine, ecstasy, methamphetamines, or heroin, among others. If I fail to comply, I will receive **NO** further medications and I will be **DISCHARGED** from this clinic.
- I **AGREE** to random/unannounced supervised drug screening to confirm that I am taking my medications as prescribed, and that I am only taking my prescribed medications. I understand that a drug screen is a laboratory test in which a sample of my urine, blood or saliva is checked to confirm which drugs I have been taking. A failed drug screen **MAY** result in **DISCHARGE** from the clinic.
- I will **IMMEDIATELY** report **ANY** addiction to illicit drugs, prescription drugs or alcohol to my provider at this clinic. **ANY** occurrence will be handled on an individual basis by the provider, as per our treatment policies, and may result in **DISCHARGE** from the clinic.

- I will **IMMEDIATELY** notify my provider if I enroll in a drug or alcohol treatment program, or if I am hospitalized for the treatment of drug addiction or alcohol abuse.
- I will **IMMEDIATELY** notify my provider if I am prescribed Suboxone (buprenorphine) for opioid addiction.
- I will **IMMEDIATELY** notify my provider if I am charged with or convicted of selling my medications, altering or forging a prescription, or **ANY** other drug regulations.
- If it is discovered that I sell my medications, alter or forge my prescriptions, or violate **ANY** other drug regulations, I will be **IMMEDIATELY DISCHARGED** from Medstar Health Solutions, and I understand that I will be reported to the appropriate authorities.
- I agree to participate in any medical, psychological/mental health assessments/treatment plans recommended by my provider.
- I will actively participate in any program designed to improve function/quality of life, including physical and occupational therapy, psychological and social training, and daily or work activities, among others.
- I will **ACCURATELY** provide my past medical history, past psychiatric/mental health history, as well as any current symptoms to my provider, and I will promptly **NOTIFY** my provider of any pertinent changes.
- I will **IMMEDIATELY** notify my provider of any **SIGNIFICANT** changes in my mental health status, such as worsening depression, suicidal thoughts or suicide attempts.
- **(WOMEN ONLY)** I will **IMMEDIATELY** notify my provider if I become pregnant. If this occurs, I understand that my care will be transferred to an OB-GYN provider until after delivery.
- If I have an allergic reaction to my medication(s) or my medication(s) fail to adequately control my pain, I will inform my provider. I will **NOT** discard/flush the medication(s). Instead, I will bring the remaining medication(s) to my next office visit to be appropriately discarded.
- I will keep all my scheduled appointments. If I need to cancel an appointment, I will do so a minimum of 24 hours before it is scheduled. Failure to show-up for my appointment on multiple occasions, or if I repeatedly cancel/re-schedule, may result in **DISCHARGE** from the clinic.
- I will keep Medstar Health Solutions informed of all **ACCURATE** primary and emergency contact addresses and telephone numbers.
- I will be **DISCHARGED** from the clinic if I am belligerent or abusive to the staff.

- If my behavior is inconsistent with the responsibilities outlined above, or if I fail to follow any of our clinic treatment policies, I may be **DISCHARGED** from the clinic.

Attestation: I acknowledge that I have read (or have had read to me) this entire document, and that I **FULLY** understand and **AGREE** to abide by its' contents. Failure to comply with this agreement may result in discontinuation of my opioid and/or controlled substance(s) and I may be **DISCHARGED** from the clinic. I also I understand that the development and implementation of my treatment plan is at the **SOLE** discretion of the treating nurse practitioner and/or the clinic medical director. Medstar Health Solutions is **NOT** obligated to prescribe medications to its' patients, and will **ONLY** do so when deemed medically necessary.

Signed: _____ Date: _____

Provider Signature:_____ Date:_____