David M. Wall, MD

Specializing in Minimally Invasive Spine Care and Treatment of Pain

1700 McMullen Booth Road, Suite A2-1, Clearwater, Florida 33759

P: 727-724-6373 F: 727-724-6377

Medical Records Release Authorization
In order to avoid a delay this form must be completed in its entirety.
PLEASE PRINT CLEARLY

Patient Name:____ Maiden Name:_______________________________

D.O.B. **(Required)**__________________________________ SS#**(Required)**_____________________________

Home Phone:____ Work Phone: _________________________________

Permission is hereby granted to David M. Wall, MD to release medical information to the individual / organization as noted below or to have records released to David M. Wall, MD:

Mail ☐ Name:____

Address:____

City/State/Zip:____

☐ Fax to another medical entity (____)___________________________

☐ call when ready for pick up (____)___________________________

☐ Person picking up records

Please check information to be released:

- ☐ All records, excluding records from other physicians.
- ☐ Surgical Records
- ☐ Therapy reports
- ☐ Diagnostic test results
- ☐ Other ____
- ☐ Office Notes only
- ☐ X-ray/MRI films
- ☐ X-ray/MRI reports
- ☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner.____

Date

I understand I have the right to refuse this authorization, in writing, and David M. Wall, MD is released from all legal liability that may arise from the released information requested.

____ __________________________

Signature of patient/Legal Guardian Date

PATIENT / PHYSICIAN AGREEMENT

FAILURE TO FOLLOW PHYSICIAN ORDERS

“Physician Orders” are meant to improve and/or resolve the patient’s medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient’s failure to follow orders. Not following orders given can include but is not limited to missing, postponing, or refusal of additional tests to rule out, confirm, or discover illness. Also, missing postponing, or refusal of making scheduled appointments can be considered failing to follow physician’s orders. I have read, understand, and agree with the above.

Patient/Guardian Signature:______________________________ Date:______________________

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature:______________________________ Date:______________________

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand, and agree with the above.

Patient/Guardian Signature:______________________________ Date:______________________

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to David M. Wall, MD to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from David M. Wall, MD a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me David M. Wall, MD may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature:______________________________ Date:______________________

CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature:______________________________ Date:_______________________

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information:

____

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to David M. Wall, MD sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect David M. Wall, MD. If applicable, I also authorize my attorney to **release any and all information** without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of David M. Wall, MD's unpaid sum.

I fully understand that I am directly and fully responsible to David M. Wall, MD for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is **not** contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby further give my authorization to David M. Wall, MD to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the Tortfeaser. I have read, understand, and agree with the above.

Patient/Guardian Signature:______________________________ Date:_______________________

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS ARE ACCURATE.

Patient/Guardian Signature:______________________________ Date:_______________________

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Assignment of Benefits

Patient:____ Date of Loss:_____________________

Insurance Carrier:______________________________________ Claim #:________________________________

Policy Owner's Name:____________________________ Policy #:________________________________

For and in consideration of (PATIENT'S NAME):____________________________________ agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment of services, I hereby irrevocably assign ALL rights and benefits to WALL HEALTHCARE, INC for Personal Injury Protection, Medical Payment Coverage and other benefits which I may have in accordance with Florida stature 627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize WALL HEALTHCARE, INC. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITIUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS AS CONTEMPLATED IN PROGRESSIVE AMERICAN INS. CO. V. STAND-UP MRI OF ORLANDO, 990 SO.2D3 (FLA. 5TH DCA 2008).

I hereby further give a lien to WALL HEALTHCARE, INC. against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injures or illness for which I have been treated by WALL HEALTHCARE, INC. as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with all employees of WALL HEALTHCARE, INC. and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to WALL HEALTHCARE, INC. including but limited to: disclosing my medical condition, being available for factual discovery, or any other means of cooperation.

WALL HEALTHCARE, INC. hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreed by the provider to accept a reduced amount as payment in full.

This assignment concerns amounts due WALL HEALTHCARE, INC. and those costs including but limited to: attorney fees, court costs, special report or narrative fees, other costs, and interest necessary to procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible/s, co-insurance/s, co-payment/s, or any not covered items by any policy of the insurance cited above. I understand that as a benefit and convenience to me,

WALL HEALTHCARE, INC. will bill and pursue collection against the insurance company or other responsible party on my behalf. I hereby instruct and direct my insurance company to pay benefits directly to WALL HEALTHCARE, INC. at the address provided on the bill.

WALL HEALTHCARE, INC.'s medical care is being provided for a reasonable fee for treatment casually related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. I hereby give WALL HEALTHCARE INC. limited Power of Attorney to endorse and sign my name on any draft for payment to WALL HEALTHCARE, INC.

This agreement is intended to serve as an absolute assignment of rights and benefits under my policy of insurance in favor of WALL HEALTHCARE, INC. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this agreement shall be considered as effective and valid as the original.

As WALL HEALTHCARE, INC. stands in my shoes by virtue of this assignment, the following constitutes rights now owned by WALL HEALTHCARE, INC., as I have directed herein, and WALL HEALTHCARE, INC. hereby demands, including but limited to:

A. Providing a copy of any applicable insurance policy, declaration page, all applicable endorsements.
B. Transcripts and/or copies or recorded statements, examinations under oath, affidavits of the claimant, affidavits of any provider who treated me, or other sworn statements pursuant to Addison v. Geico General Ins. Co., 17 Fla. L. Weekly Supp. 272a (Hills. Cty. Ct. 2010).
C. Copies of independent or compulsory evaluation, including peer reports or other reports pursuant to 627.736(7) of me.
D. Any police or accident report my insurance company may have for the above listed date of loss.
E. A listing of all PIP benefits paid to date on my behalf of AND to me which shall include claims were received, the amount of the claim before reductions or repricing, payment amount or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP LOG" of "PIP PAYOUT LOG". This is specific to include ALL medical, disability, and death claims under accordance with Florida statute 627.736 and the names of each biller and payee.
F. Providing notice or any request under any cooperation clause of the policy, including but not limited to: requests for EUO or IME attendance to our office as WE STAND IN THE SHOES OF THE INSURED. Any EUO or IME taken without providing us reasonable notice and allowing counsel of our choosing to attend is INVALID.
G. All notices and requests for information under Florida Statute 627.736(6)(b) are to be directed to our attorney, PHILLIP A. FRIEDMAN, ESQ., FL LEGAL GROUP, 501 E Kennedy Blvd., Ste. 810, Tampa, Florida 33602

Patient/Guardian's Name   Patient/Guardian's Signature   Date

IF PATIENT IS INCAPACITATED OR UNDER THE AGE OF 18, PLEASE INDICATE THE PATIENT NAME, GUARDIAN NAME RELATION TO PATIENT, AND OBTAIN GUARDIAN SIGNATURE.

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NOTICE OF PRIVACY PRACTICES

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.

At Wall Healthcare**,** we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act hat requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

____

Patient/Guardian (Please Print Name)   Patient/Guardian (Signature)   Date

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Patient Information

Today's Date____________________ Home Phone____________________

Name____________________ SS#____________________

Address____________________ Cell Phone____________________

City____________________ State__________ Zip__________

Sex ☐M ☐F DOB____________________ ☐Married ☐Widow ☐Single ☐Divorced/Separated ☐Minor

Patient Employer/School____________________ Occupation____________________

Employer/School Address____________________ Phone____________________

Emergency Contact____________________ Phone____________________

Family/Referring Dr____________________ Phone__________ Fax__________

Primary Insurance

Insured Name____________________ DOB____________________

Address (if different than above)____________________ Phone____________________

City____________________ State__________ Zip__________ SS#____________________

Insured Employer____ Wk Phone__________________

Insurance Company____

Subscriber ID #____________________________________ Group #____________________

Insurance Address____ Phone____________________

City____________________________ State________ Zip______________ Fax #________________

Do you have secondary insurance? ☐Yes ☐No (If yes) Insurance Co.____________________________________

Worker's Compensation or MVA Information

Claim #____ Date of Injury____________________

WC/MVA Co. Name____ Phone____________________

Address for Claims____

Adjuster Name________________________________ Phone________________ Fax______________

Attorney Name________________________________ Phone________________ Fax______________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize David M. Wall MD, or insurance company to release any information required to process my claims.

____

Patient/Guardian Signature Date

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Patient:____Age: __________DOB: ______________

Height:___________ Weight:______________ _____ Auto/ Motorcycle Injury ____ Slip & Fall ___ Pedestrian

Date of Injury: _____________ Today's Date:_____________

What is the main reason you are here.

____

If this was as a **result of an accident** please explain exactly how you were injured, if not, skip to section 2 below

____

____

Were you the ___ Driver ___ Passenger ____ Front ___ Back Did you have on your seatbelt ___ Yes ___ No

Did you strike your head against the vehicle? ___ Yes ___ No Did you lose consciousness ___ Yes ___ No

Did any parts of your body strike the vehicle or the ground , please list which areas ___________________________

___________________, ________________________, _____________________________,
____

Following the injury, did you go to the hospital ____ Yes ___ No Admitted? ___ Yes ___ No

Name of Hospital ________________________________

Please indicate any of the procedures performed at the hospital ___ Surgery ___ CAT scan

____ X rays ____ Prescription for medications provided _____ Stitches (continue to Section 2)

Section 2

Please indicate all doctors you have seen for this medical condition and the type of care they have provided. If none, please skip

Doctor ___________________________________ Date seen ____

Treatments ____

Doctor ___________________________________ Date seen ____

Treatments ____

Doctor ___________________________________ Date seen ____

Treatments ____

Doctor ___________________________________ Date seen ____

Treatments ____

Doctor ___________________________________ Date seen ____

Treatments ____

Please check any of the following medical treatments you have had FOR YOUR INJURIES

_____ Surgery for _________________________ Name of doctor _____________________

_____ Injections Areas injected _______________ Name of doctor ______________________

Did Treatment help? ____ Yes ____ No Explain _____________________________________

(For below, please check if this pertains to your pain)

Please describe each painful area you have at this time

______ **Low Back Pain**

___ Ache ___ Burning ___ Sharp ___ Other ___________________________________

Does pain travel to either buttock or leg ___ Yes ___ No If yes, ___ Left ___Right leg

If yes, describe the pain ____

Please check any of the following you have in your legs ____ Numbness ____ Pins and needles

____ Weakness in my ____ Left / Right / Both leg(s)

Does anything lessen your pain? ___ Yes ___ No Describe __________________________

Does anything worsen your pain? ___ Yes ___ No Describe __________________________

___ Previous injuries, if any, to Low Back ____ Completely recovered ____ Still had pain from old injury,

Please note how new pain is different than old ____

_____ **Neck Pain**

___ Ache ___ Burning ___ Sharp ___ Other ___________________________________

Does pain travels to either arm ___ Yes ___ No If yes ___ Left ___ Right arm

If yes, describe the pain ____

Please check any of the following you have in your arms ____ Numbness ____ Pins and needles

____ Weakness in my ____ Left / Right / Both arm(s)

Does anything lessen your pain? ___ Yes ___ No Describe __________________________

Does anything worsen your pain? ___ Yes ___ No Describe __________________________

___ Previous injuries, if any, to Neck ____ Completely recovered ___Still had pain from old injury

Please note how new pain is different than old ____

_____ **Headaches** that are in ____ Front of head ____ Back of head ____ All of head

with ____ dizziness ____ change in vision ____ passing out ___ nausea and vomiting

Additional comments ____

Additional Painful Area (where?)____

___ Ache ___ Burning ___ Sharp ___ Other ______________________________

Does pain travels to another area of your body from original area ___ Yes ___ No

If yes, describe ____

Does anything lessen your pain? ___ Yes ___ No Describe ______________________

Does anything worsen your pain? ___ Yes ___ No Describe ______________________

Additional comments (ex. Popping, Locking)____

Additional Painful Area (where?)____

___ Ache ___ Burning ___ Sharp ___ Other ______________________________

Does pain travels to another area of your body from original area ___ Yes ___ No

If yes, describe ____

Does anything lessen your pain? ___ Yes ___ No Describe ______________________

Does anything worsen your pain? ___ Yes ___ No Describe ______________________

Additional comments (ex. Popping, Locking)____

Please list all injuries **before this one**, if any, AND treatment received (Ex therapy, surgery, injection).

Injury / Date	Describe Treatment	Recovered
________________	____	Yes / No
________________	____	Yes/ No
________________	____	Yes/ No
________________	____	Yes/ No

Past Medical History

Check all that apply

_Diabetes	_High Blood Pressure	_Heart Disease	_Heart Attack
_Asthma	_Bronchitis or Emphysema	_Seizure history	_Ulcers
_Hypo/Hyper Thyroid	_Rheumatoid Arthritis	_History of Cancer	_Blood Clots
_Kidney disease	_Hepatitis	type: _____________	
_Other:__________	_ HIV+ (this will not be disclosed)		

Past Surgical History

Please list any surgeries you have had ____________________________________, _________________________

_____________________________, ____________________________________, _________________________

CURRENT MEDICATIONS (List all medications you are taking NOW -use back of this sheet if you need more room)

MEDICATION	DOSAGE	# Per Day /Frequency	Reason for Taking (if known)
___________________________	_________	___________________	________________________
___________________________	_________	___________________	_______________________
___________________________	_________	___________________	_______________________

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO List name <u>and describe reaction</u>

____
____
______

Family Medical History

Has anyone in your family had an adverse reaction to anesthesia: Yes No

Has anyone in your family had a history of alcoholism or drug addiction Yes No

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER ________________________

Do you smoke tobacco? YES NO How much? ______ packs per day How long? ______ years

Do you drink alcohol? YES NO How much? _________drinks per day How long? _______years

Do you use any street drugs? YES NO (These may interact with medication we prescribe so we must know)

Have you previously had a history of ___ alcohol abuse ___ drug abuse When did you discontinue use______________

Occupation ____________________________ Time lost from work ____

Have you returned to your workplace ____ Yes ___ No

DO YOU HAVE ANY PROBLEMS RELATED TO THE FOLLOWING?

Neurological

Tremors Y N

Dizzy Spells Y N

Gastrointestional

Abdominal Pain Y N

Nausea/Vomiting Y N

Rectal Bleeding Y N

Ulcers Y N

Respiratory

Frequent Cough Y N

Short of Breath Y N

Wheezing Y N

Hemotologic/Lymphatic

Blood Clots Y N

Easy Bleeder" Y N

General

Fever Y N

Weight loss Y N

Cardiovascular

Chest Pain Y N

High B.P. Y N

Heart Failure Y N

Musculoskeletal

Joint Pain Y N

Muscle Aches Y N

Fiibromyalgia Y N

Psychologic

History of depression Y N

History of bipolar disorder Y N

History of schizophrenia Y N

Genitourinary

Urine Retention Y N

Loss of bladder control Y N

Other Medical Conditions that we should be aware of that you have not mentioned so far:

____

____

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Medication Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your 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.

1. You should use **ONE** physician to prescribe and monitor all opioid medications and adjunctive analgesics.

2. You should use **ONE** pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.

   Pharmacy: _______________________ Phone Number: ____________________

3. You should inform your physician of all medications you are taking, including herbal remedies, medications, especially cough syrup that contains alcohol, codeine or hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is **NOT** to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

5. Prescriptions for pain medicine or any other prescriptions will be done only during and office visit or during regular office hours. **NO** refills of **ANY** medications will be done during the evening or on weekends.

6. You must bring back **ALL** opioid medications and adjunctive medications prescribed by your physician in the original bottles.

7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. **Stolen medications should be reported to the police and to your physician immediately!** If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications.

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law!
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

10. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits, your pain level and functional activity along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

11. You should not use any illicit substances, such as cocaine, marijuana, etc… while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

12. The use of alcohol and opioid medication is contraindicated

13. You agree and understand that your physician reserves the right to perform random unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing)

15. Physical dependence and/or tolerance can occur with the use of opioid medication.

    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, chills, and alterations in ones mood.

    It should be noted the 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 ones quality of life.

Tolerance means a state of adaption in which exposure to the drug induces changes that result in diminution of one or more of the drugs 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.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for 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.

17. You agree to allow your physician to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it necessary.*

18. You agree to a family conference with a close friend or significant other *if the physician feels it necessary.*

I agree to these terms so that David Wall, MD and his staff can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Patient Signature: _________________________________ Date: _________________

Witness Signature: ________________________________ Date: _________________