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PATIENT REGISTRATION AND INFORMATION

Name: **Social Security Number:**

Address: **Home Phone:** **Cell Phone:**

City, State & Zip Code: **Email:**

Sex: **M** **F** **Date of Birth:** **Marital Status:**

Employer: **Occupation:**

Business Address: **Business Phone:**

Referring Doctor:

Emergency Contact: **Phone Number:**

SPOUSE INFORMATION

Name of Spouse: **Social Security Number:** **Date of Birth:**

Spouse's Employer: **Phone Number:**

RESPONSIBLE PARTY

Person Responsible for Payment:

Relationship to Patient: **Date of Birth:** **Social Security Number:**

Address (if different from patient): **Phone Number:**

City, State & Zip Code:

Responsible Party Employed By: **Occupation:** **Work Phone:**

INSURANCE INFORMATION

Primary Insurance: **Subscriber:** **Date of Birth:**

Billing Address: **City,** **State,** **Zip Code:**

Employer/Address: **Insurance ID#:** **Group ID#:**

INSURANCE INFORMATION

Secondary Insurance: **Subscriber:** **Date of Birth:**

Billing Address: **City,** **State,** **Zip Code:**

Employer/Address: **Insurance ID#:** **Group ID#:**

Is your injury work related?: Yes No **Is your visit personal injury related?: Yes No**

If you answered yes to the above question and are represented by an attorney, list their name, address and phone below:

ASSIGNMENT AND RELEASE

I, undersigned certify that I (or my dependent) have the above stated insurance coverage and assign directly to PPA all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize PPA to release any information necessary to secure payment of benefits on all insurance submissions. Further, I authorize the release of my medical records from the office either myself, or any and all medical personnel necessary for my continued medical care. In providing this consent, I am fully aware that the physicians of PPA, the staff, and employees cannot be responsible for the confidentiality of the information disclosed after medical records have been released. Therefore, the physicians of PPA, the staff, and employees are released from any liability arising from such disclosure.

Patient Signature: Date:

Responsible Party Signature: **Date:**

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PATIENT INFORMATION/HISTORY FORM

Name:

Last: First MI

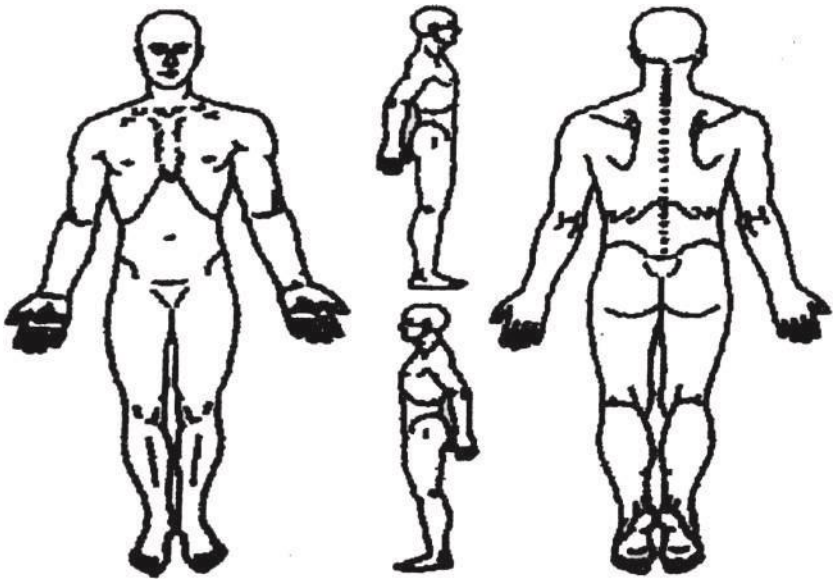
Age: _____ **Sex: Male Female** **Weight:** _____ **Height:** _____

Primary Care Doctor: _____

Please describe your main pain problems:_____

_____

Indicate on the picture below the area(s) of your pain. Use "X" for pain and "O" for numbness.



When did your pain start? (Approximate date):_____

How did your pain start?_____

Is your pain constant? ☐ **Or comes and goes?** ☐

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Present level of pain intensity (check box next to number):

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No Pain Mild Moderate Severe Excruciating

What words best describe your pain? (Check as many as apply):

Sharp ☐ Burning ☐ Throbbing ☐ Shooting ☐ Aching ☐ Cramping ☐ Dull ☐ Tingling ☐

Coldness ☐ Hotness ☐ Electricity ☐ Other: _____

_____

What brings on the pain or makes it worse (check as many as apply):

Sitting ☐ Standing ☐ Walking ☐ Twisting ☐ Lifting ☐ Sneezing ☐ Coughing ☐ Using Arms ☐

Bending forward ☐ Bending backward ☐ Other: _____

_____

What eases or eliminates the pain? (Check as many as apply):

Lying down ☐ Standing ☐ Exercise ☐ Arthritis Medicine ☐ Pain Pills ☐ Muscle relaxants ☐

Nothing ☐ Other: _____

_____

Do you have any loss of control of your bowels or bladder? Yes ☐ No ☐

Do you have pain that shoots down your arms of legs? Yes ☐ No ☐

Do you have any increasing weakness in your arms or legs? Yes ☐ No ☐

Please mark all the following medical problems that you have had (check as many as apply):

Heart problems ☐ Heart Attack ☐ High Blood Pressure ☐ Stroke ☐ Blood Clots ☐ Diabetes ☐ Asthma ☐

Kidney Failure ☐ Kidney Infections ☐ Liver Problems ☐ Thyroid Problems ☐ COPD ☐ Lung Problems ☐ Depression ☐

Headaches ☐ Glaucoma ☐ Seizures ☐ Ulcers ☐ Hepatitis A/B/C ☐ Immune Disorder ☐ Cancer:_____

Other: _____

Please list all past surgeries you have had:

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

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Please list all current prescription medications and any other medications:

Medication	Dose and Frequency

Do you have any medication ALLERGIES? No: _____ Yes: _____

_____

Please list any pain medications you have tried in the past: _____

_____

_____

Do you take any of the following medications (check all that apply): Coumadin ☐ Asprin ☐ Plavix ☐ Lovenox ☐ Heparin ☐

Please indicate which tests you have had to evaluate your present pain (with date):

MRI: _____ **CT Scan** _____ **Myelogram** _____ **Bone Scan** _____

Discogram _____ **EMG** _____ **Other:** _____

Please list any procedures you have received for you pain (with date): _____

_____

Please list any other treatments you have received for pain (TENS, chiropractic, physical therapy, biofeedback):

_____

WORK HISTORY

What is/was your occupation? _____

Work full time ☐ **part time** ☐ **Unemployed** ☐ **Homemaker** ☐ **Retired** ☐ **On Disability** ☐

Other _____

When did you last work? _____

If your pain is work related, what was the date of your injury? _____

Do you currently have an attorney in regards to your pain condition? Yes ☐ **No** ☐

If yes, please provide name and phone number?_____

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Social History:

Are you: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐
Do you have children? _____ How Many?_____

Who lives in your home with you?_____

Do you smoke? Yes ☐ No☐ If yes, how many packs of cigarettes per day? _____

Are you a former smoker? _____ If yes, when did you quit? _____

Do you drink alcohol? _____ If yes, how much in a week? _____

Do you have a history of alcohol, street drugs, or prescription medicine abuse? Yes ☐ No ☐

Have you ever been arrested or convicted on a drug related charge? Yes ☐ No ☐

If yes, please explain and provide date? _____

_____

_____

SLEEP AND MOOD:

How many hours a night do you sleep?

_____

Have you ever been diagnosed with depression, psychosis, schizophrenia, or bipolar disorder? If, yes, which one(s)?

_____

Are you seeing a psychiatrist or psychologist? Yes ☐ No ☐ For what? _____

Do you have any thoughts of hurting yourself or others? Yes ☐ No ☐ If yes, please explain: _____

_____

Do you have family history of any of these problems? (Check as many as apply)

Alcoholism ☐ Depression ☐ Substance abuse ☐ Mental illness ☐ Cancer ☐ Heart problems ☐
Stroke ☐

Please provide us with any additional information that you feel would assist us in treating your pain?

_____

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Patient Name: _____

Please check if any of these apply to you:

Pregnant: Yes ☐ No ☐

General: Fever ☐ Weight loss/gain ☐ Poor appetite Sexual problems ☐ Insomnia ☐

Neurological: Headache ☐ Seizures ☐ Paralysis ☐ Confusion ☐ Disorientation ☐ Numbness ☐ Tingling ☐

Eye, Ear, Nose, Throat: Blurry vision ☐ Trouble Swallowing ☐ Loss of hearing ☐ Voice changes ☐

Respiratory: Emphysema ☐ Shortness of breath ☐ Bronchitis ☐ Asthma ☐ Tuberculosis ☐

Cardiovascular: Chest pain ☐ abnormal heart beats ☐ Heart failure ☐ Heart murmurs ☐

Gastrointestinal: Nausea ☐ Vomiting ☐ Blood in stool ☐ Constipation ☐ Hepatitis ☐ Pancreatitis ☐

GU: Blood in urine ☐ Recurrent urinary infections ☐ Trouble urinating ☐ Kidney Stones ☐

Musculoskeletal: Rheumatoid arthritis ☐ Lupus erythematosis ☐

Skin: Rash ☐☐ Open sores ☐☐ Recurrent infections ☐☐ Tumors ☐ Skin cancer ☐

Endocrine: Diabetes ☐ Thyroid problems ☐ Adrenal dysfunction ☐ Pituitary problems ☐

Hematologic: Leukemia ☐ Lymphoma ☐ Anemia ☐ Bleeding gums ☐

Other: _____

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Acknowledgement of Medication Policy

If you live outside a 75 mile radius of our clinic we are willing to mail you your prescriptions through priority mail; however you will be required to pay an annual fee of $100.00 up front before we will begin mailing your prescription refills. With this being said you may at times be required to come in and pick up your prescription this is up to the physicians discretion and they may require a UA sample and/or a pill count of your medications.

If this fee is not paid or you do not live outside the 75 mile radius then you will be required to come into our office to pick up your prescriptions on the months you are not seeing the provider.

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HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

Patient or Patient Legal Representative Signature **Date**

Please provide us with a list of names of whom you would allow our office to release medical info to and pick up perscriptions.

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been informed of Premier Pain Associates's (PPA) Notice of Privacy Practices:

- **It tells me how PPA will use my health information for the purposes of my treatment, payment for my treatment, and its health care operations.**
- **The Notice explains in more detail how PPA may use and share my health information for purposes other than treatment, payment, and health care operations.**
- **PPA will also use and share my health information as required/permitted by law.**

Patient's Complete Legal Name (please print):_____

Patient's Date of Birth:_____

Date:_____

Patient's Signature (Patient or legal representative*):_____

Reasons:
Patient declined the Notice of Privacy Practices. ☐

_____

Patient/Employee Signature:_____

Date:_____

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Narcotic Medication Risk

I understand that I should never combine alcohol, illicit drugs such as marijuana, cocaine, heroin, methamphetamine or other illegal drugs with prescription medications, as these combinations are highly dangerous. I understand that if these substances are found in my urine or blood tests that my physician may no longer prescribe medications to me. It has been explained to me that some common toxic effects are:

- **Central nervous system depression, which can range from drowsiness (at its mildest) to coma (at its most severe)**
- **Respiratory depression, which can lead to a person to stop breathing**
- **Cardiac effects, such as changes in heart rhythm that can lead to the heart stopping**
- **Decreased seizure threshold, meaning that the brain can have a seizure more easily**
- **Psychiatric effects, such as psychosis**

After carefully reading and understanding the above terms, I request treatment by the PPA (to include narcotic medications if appropriate), and promise to follow the terms of this contract and the medication policy of PPA.

Patient's Name: _____

Date: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Witness Name: _____

Date: _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Oklahoma law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____Age:___ DOB._____ Sex_____ SSN_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____

I herby authorize, Premier Pain Associates of Oklahoma to __Release or ___Obtain (Check One)

Information and copies of records pertaining to my medical care and treatment.

I request my medical Records

____Entire Chart ____Other _____

Release To:
Premier Pain Associates
1150 E. Lansing
Broken Arrow, OK 74012 Phone 918-760-5346
Obtain From:
Doctor/Facility/Hospital Name
Address
City, State, Zip Code

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG, SUBSTANCE, OR ALCOHOL ABUSE.

I understand that if I am requesting records/information for release to me or patient representative:

- Laws may prevent certain records being released to the patient
- In certain situations, records denied for release to the patient may all patient to request and obtain review of the denial Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization

- Will expire in 12 months or on _____(Date)
- May be revoked in writing care of the Medical Records Custodian, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected
- Is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of this authorization is to determine payment of a claim for benefits
- Is required for employment-related substance/alcohol screening

Warning: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party. Release: I release Premier Pain Associates listed above, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this authorization.

Signature of Patient _____Date:_____Person Authorized to sign for Patient_____ Relationship to Patient _____ Date_____

Nurse Practitioner Consent

Premier Pain Associates would like for you to know that they employ Nurse Practitioners to assist them in a "team approach" to their high quality delivery of chronic pain management care.

A Nurse practitioner is a Registered Nurse who has received advanced education and training in the provision of healthcare. Nurse Practitioners are not doctors. The Nurse Practitioners of PPA are able to diagnose, treat, and monitor routine and complex pain disorders. If you are seen by one of our NP's your care can be reviewed with the doctor as needed as part of your care and treatment plan.

I have read the above and understand that in this practice, a "team approach" is used, with my unique problems and/or needs presented and discussed with one or more physicians in the development of my care plan. The team approach allows us to assess and assign the needs of the patient to the most appropriate staff member, and ensures that you are seen in a timely fashion. The physician is always available if any urgent matter is noted during your visit. I also understand that one physician will direct my overall care, but that from time to time, I may be seen by any or all the practitioners in this practice, including a Nurse Practitioner.

I understand that any follow-up appointment may be scheduled with a Nurse Practitioner, and that I can refuse to see the Nurse Practitioner and request to see the doctor, but that requesting to see another provider will likely require that my appointment be rescheduled. Additionally I understand that refusing to see one of PPA providers may result in my no longer being able to be treated by the practice.

By signing this agreement, I affirm that I have read, understand, accept, and consent to the services of a Nurse Practitioner for my health care needs.

Signature_____ Date_____

Printed Name _____

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Premier Pain Associates will require patients to keep scheduled appointments. If you fail to give a 24 hour notice, medications may not be refilled and patients will be required to pay a No Show/Late cancellation fee of $40.00 before they can reschedule appointment. If you are scheduled for a procedure and you fail to give us a 24 hour notice you will be charged $75.00 before they can reschedule the procedure

Patient's Name: _____

Witness Name: _____

Date: _____

Patient's Signature:_____

Witness Signature:_____

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Refilling Your Medications

You will be required to pick up your prescriptions from our office each month. Refills will ONLY be given at your appointment with one of our providers OR at your appointment with the prescription nurse. You will be scheduled for a nurse visit to discuss your medications during the months that you are not seen by one of the PPA providers. This will be done to monitor your compliance with your treatment regimen and to closely monitor for any evidence of problems or adverse effects you may be having with your medications. It will also allow you to discuss any questions or concerns you may have about your medications with a member of our clinical staff.

Due to the nature of the type of medications our physicians and providers prescribe and the increasing accountability and strict guidelines that must be followed. In doing so, we will only be able to mail prescriptions to addresses over 75 miles away, and you will be required to have a telephone nurse visit prior to prescriptions being issued.

It is imperative that you keep your scheduled appointments, as missing them may result in running out of your medication. Due to busy appointment schedules and many patients needing our services, we may not be able to reschedule your appointment before you run out of your medications. If you are not able to get in before your medication runs out, it is recommended that you try to stretch it out instead of abruptly stopping it. Medication can be given to help with withdrawal symptoms, but your controlled medications may not be refilled until you are seen in the office.

Refills will be given ONLY during office hours (M-F 9:00-12:00 and 1:00-3:00) Closed from 12:00 – 1:00 for lunch). No refills will be given after hours or on weekends. Do not call for prescriptions after hours or on weekends.

Each prescription given is for a 30 day supply (unless otherwise discussed with you). The number of days in the month is irrelevant to how many pills you receive. Your refill date may or may not be on the same date each month. We allow you to fill your prescription on the last day (day 30) of each current prescription, so that you have your new prescription to start the next morning (day 1). Exceptions to the Day 30 refill may be made ONLY if your refill day falls on a weekend AND your pharmacy is closed on Saturday or Sunday, which we will verify prior to allowing an early refill.

If you are leaving town, you will need to make arrangements to have your prescriptions filled at another pharmacy. If you are leaving the state, you will need to make arrangements to have your prescriptions picked up at your pharmacy by a trusted individual and mailed (we recommend Fed-EX with signature upon delivery) to you at your destination.

Medication Agreement

Dear patient,

On behalf of PPA, we wish to thank you for allowing us to participate in your care. We hope that we will make a difference for you.

There have been several important developments in the State of Oklahoma that will effect and improve our care for your chronic pain. Over the past several years, the use of strong prescription pain medication has increased in our state. This is partly due to the improving recognition of the importance of pain management in the health and welfare of patients. However, misuse of strong prescription pain medications have also increased, resulting in increased rates of addiction, abuse, and serious side effects, including death. We as providers place ourselves at significant risk when using our DEA numbers to prescribe narcotics and other controlled medications.

In order to continue to safely treat our patients with the best quality treatment, and to comply with guidelines from the State and Federal Governments, we have prepared the following policies to ensure your safety and our continued ability to treat you in the most effective and safe way possible. Please read this carefully. These policies are for your protection, as well as ours, and **WILL BE ENFORCED**. By initialing in the appropriate areas and signing the following terms, you are agreeing to strictly follow these terms, and thus entering into a contract with PPM for continued care for your chronic pain condition.

1. I understand that my first visit may be a consultation only and that no pain medication may be given at the time if further investigation and/or testing is deemed necessary. Guidelines for prescribing controlled medications are very specific and may require us to contact your previous physicians before we can establish medical necessity for refills. This process can take weeks to accomplish. We recommend that you bring ANY and ALL records, including names of all past physicians, pain treatments, surgeries, pharmacy names, etc., as it can help speed the process. _____(initial)
2. I must take my medication ***only as prescribed*** by my physician/providers. Misuse or overuse of my medication can lead to adverse side effects (including death) and possible discontinuation of any controlled medications._____(initial)
3. I must not obtain or take any pain medication given to me by another person or physician/provider unless specifically directed by my PPA provider. In the event of an emergency. If I do obtain controlled substances from another provider, I understand I am required to disclose this information to PPA within 48 hours of discharge or emergency service. I understand it is my responsibility to make sure PPA is notified of any such treatments and that I am to check with my provider at PPM before increasing my medications combining any pain medication with the prescriptions they provide me.____(initial)
4. I understand that combing my pain medication with excessive alcohol, anti-anxiety medications, or other sedating medications can be dangerous, and even fatal, and is not recommended by PPA providers._____(initial)
5. I will not use any illegal substances, including marijuana, cocaine, PCP, methamphetamines, ecstasy, or any legal controlled substances not prescribed to me. I understand that use of these

substances will result in discontinuation of any controlled substances and likely discharge from PPA_____(initial)

6. Pain medication is prescribed to increase my function so that I can work, participate in physical therapy, exercise programs, and weight loss programs, as indicated. If my activity level does not improve with medication, alternative methods of pain management may be substituted for medication_____(initial)
7. I understand that any medical treatment is initially a trial and that it is up to my PPA provider to determine whether or not it is medically and legally appropriate for me to continue that prescription _____(initial)
8. I understand that even though I may not notice it, my reflexes and reaction times may be slowed by taking medications, I agree that I will not be involved in any activity that can be dangerous to me or others and will not drive or operate heavy machinery if my medications cause me to feel impaired in any way_____(initial)
9. My medications must be kept in a safe place, preferably a lock box affixed securely in my home. We expect that you will take the highest degree of care and safety with your medications and prescriptions. Any medication or prescription that is lost, misplaced, stolen, destroyed, or finished early due to overuse **will not** be replaced for any reason. (*Please do not open your bottles over any sinks or toilets*.) _____(initial)
10. If my medications are stolen, I understand that they will not be replaced. In addition, I must file a police report and will be required to provide PPA with a copy of that report and a receipt of proof of purchase of a lock box before PPA will consider prescribing any further controlled medications _____(initial)
11. If I am unable to tolerate any medications, I understand I will be required to return the appropriate amount of the unused portion of the medication to the office before I may be given a different prescription._____(initial)
12. I understand that I must not share, sell, trade, or allow any other person, including children, to have access to my medications nor will I borrow or buy medications from any other person. If I engage in these activities, I am knowingly violating Federal Law._____(initial)
13. I will not alter the form of the medication, nor will I take the medication in a route other than as prescribed by my provider._____(initial)
14. All of my prescriptions should be obtained at the same pharmacy. Should the need arise to change pharmacies, I must inform PPA_____(initial)
15. I understand that the prescribing physician and staff of PPA reserve the right to discuss diagnostic and treatment with any city, state, or federal law enforcement officials during any official investigation of any possible misuse, sale, or other diversion of my medication _____(initial)
16. I understand that PPA will be verifying that I am receiving controlled substances from only one prescriber and one pharmacy by checking the prescription monitoring program website periodically throughout my treatment period. _____(initial)
17. I understand that I must be seen in the office by a provider every 2months for medications maintenance purposes and for a visit with the prescription nurse every other alternating month to pick up my prescriptions_____(initial)
18. Medication refills will be given ONLY during office hours (See information sheet regarding Medication Refills for Further Information) I understand that if I do not come in for scheduled appointments, I may run out of medication and have withdrawal symptoms. While medication can

be prescribed to minimize some withdrawal symptoms, my pain medications will not be refilled until I am seen in the office. _____ (initial)

19. If my prescription expires, I must return the prescription to PPA before another prescription will be issued to me. _____(initial)
20. I will inform and keep PPA up to date on **All** medications I am taking from any provider._____(initial)
21. PPA reserves the right to decrease, taper, or discontinue narcotic pain medications if I do not comply with other recommended and prescribed treatments, including, but not limited to adjunctive medications (muscle relaxants, nerve pain medications, anti-iflammatories, etc.) and/or other non-medication treatment, modalities (interventional therapy, exercise, physical therapy, psychological treatment, etc.)_____(initial)
22. I must keep my scheduled appointments, If I fail to appear for an appointment, my medication may not be refilled and I may be required to pay a fee of $40.00 to reschedule. If I fail to appear for more than 2 appointments I may be dismissed from the practice. _____(initial)
23. I must provide 48hours notice to cancel an appointment. If I fail to provide this notice, my appointment may be considered as a failure to appear and may be subject to the $40.00 reschedule fee and limitation of refills. _____(initial)
24. I understand that I will be subjected to randomization for urine or blood screens and PPA reserves the right to request one **at any time.** Refusal to submit a specimen, presence of unauthorized substances or abnormal results may result in discontinuation of my medications. _____(initial)
25. I understand I may be subjected to a request for a random pill count to monitor compliance with my medication treatment plan_____(initial)
26. I understand that if I altar, change, or attempt to tamper in any way with any of my prescriptions, PPA will notify the appropriate law enforcement officials. _____(initial)
27. PPA reserves the right to stop prescribing narcotic pain medications at any time if there are any violations of the medication agreement. I understand that if I am given a tapering schedule, I must follow it or I may have severe withdrawal symptom, possibly even death._____(initial)
28. I understand that non-professional or inappropriate behavior toward any CPS staff, affiliate or provider will not be tolerated. I agree to be respectful to other patients and people I may encounter in the waiting room, lobby, hallways etc. I understand that I may not loiter in the parking lot, halls, or building_____(initial)
29. PPA reserves the right to discharge me as a patient if I violate my pain contract, if I participate in any illegal activity, or if my behavior is aggressive or disruptive to the clinic_____(initial)
30. I agree to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my PPA provider deems necessary._____(initial)
31. I will notify PPA of any changes in name, address, or phone number. I understand that I must have an updated phone number with PPA at all times. I cannot be on dangerous medications, such as opioids, if my provider cannot reach me in a reasonable period of time (usually considered within 24hours of the initial attempt). I agree to return any phone call from PPA within 24 business hours_____(initial)

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I affirm that I have full right and power to sign and be bound by this medication agreement. I have read all of the information and responsibilities listed above. All of my questions and concerns regarding treatment have been adequately answered. By initialing each term and signing this agreement, I affirm that I have read, understand, and accept all of the terms of this agreement and that a copy of this document has been given to me.

This agreement is entered into this _____ day of _____, 20___.

Patient Signature: _____

Patient Name (Printed):_____

Clinic Witness Signature_____

Clinic Witness Name (Printed)_____