Amara
Pain & Spine
We strive to relieve your pain

6429 Bannington Road, Suite B, Charlotte, NC 28226
Tel: 704 503 9338 Fax: 704 503 9339
amarapain@gmail.com www.amarapain.com

First Name: _____ MI:___ Last Name: _____ Date:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Primary Language:_____ [ ] Male [ ] Female

Home Phone: _____ Cell: _____ Work Phone: _____

DOB: ___/___/_____ Social Security #: ____-___-_____

Health Care Reform laws request information on race and ethnicity, if you prefer not to answer please check the option "Decline"
Race: [ ] White [ ] Hispanic [ ] African American [ ] Asian [ ] American Indian [ ] Other [ ] Decline

Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Decline

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Who referred you to us? _____ Phone Number: _____

Who is your Primary Care Physician (PCP)? _____ Phone Number: _____

Which pharmacy would you like us to keep on your record?
Name and address_____ Phone Number: _____

PAYMENT: [ ] Insurance [ ] Self Pay [ ] Workers Compensation [ ] Auto Insurance

Commercial Insurance:
Primary insurance name: _____ Secondary insurance name: _____

Workers Compensation:
Date of injury: _____Claim number: _____ Workers Comp._____ Claim Manager: _____Phone Number:_____
Employer Name: _____Employer phone: _____
Address:_____

Auto Accident:
Date of accident:_____ Claim number: _____ Auto Insurance:_____
Claim Representative: _____ Phone Number:_____

EDUCATION: Your highest education level achieved:
[ ] Post Graduate [ ] College graduate [ ] High school graduate/GED Other_____

EMPLOYMENT:
[ ] Full-time [ ] Part-time [ ] Retired [ ] Student [ ] Homemaker [ ] Disabled [ ] Unemployed

Occupation: _____ Employer: _____

If you are unemployed or employed part-time, is this due to your present pain condition? ___ No ___ Yes
If you are currently unemployed, indicate how long you have been off work: _____

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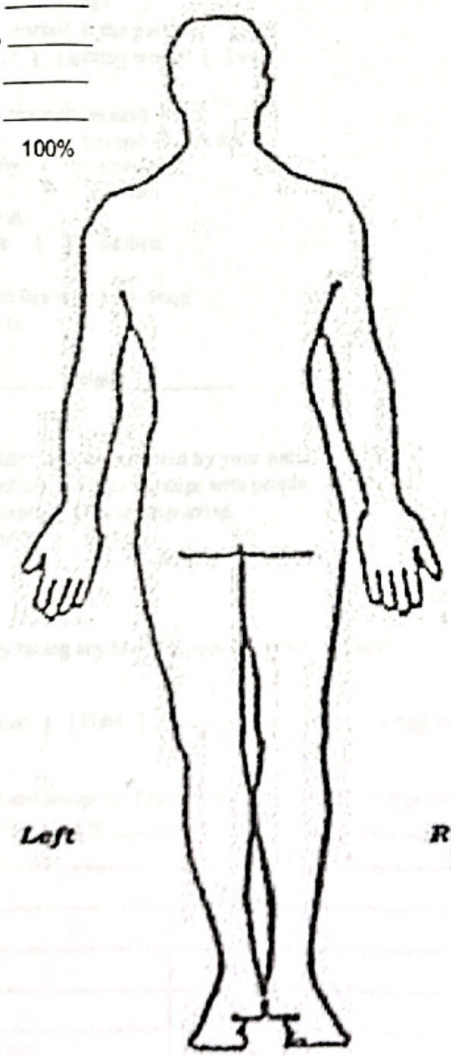
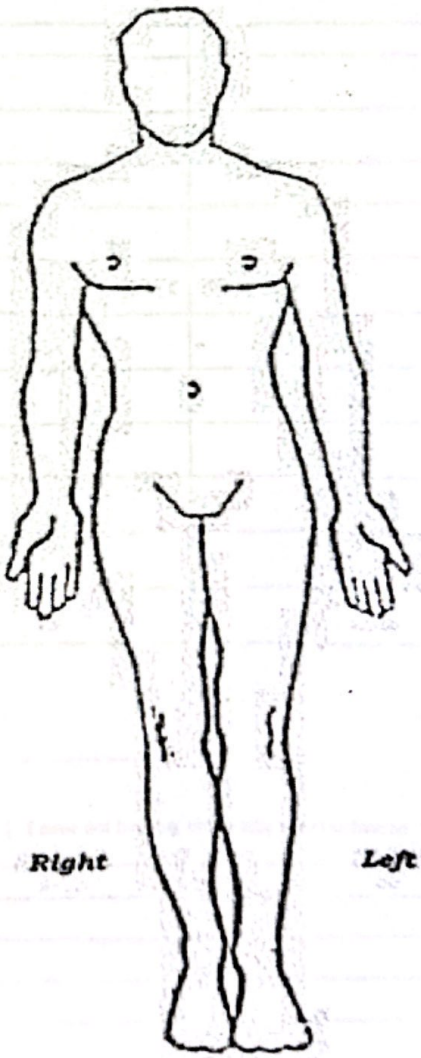
Patient Name_____Date_____
Where is the area of your worst pain located? _____
Please list any additional areas of pain: _____
Does the pain radiate, if so where? _____
[ ] Numbness/tingling: where _____ [ ] Weakness: where _____
Use alphabet below to describe your pain for, numbness - N, Weakness - W, Ache/Pain - A, pins & needles - P, Burning - B and any Radiation - R

Numbness	Weakness	Ache	Pins & Needles	Burning	Radiating pain
NNNN	WWWW	AAAA	PPPP	BBBB	///////////

Neck Pain % _____
Arm Pain % _____
Back Pain % _____
Leg Pain % _____
Total Pain 100%





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Pain score today: _____ (on a scale of 0-10)

How and when did the pain start?

Month/year _____

[ ] No obvious cause
[ ] Auto accident Date: _____
[ ] Work accident Date: _____
[ ] Other injury _____
[ ] Following surgery _____
[ ] Cancer _____
[ ] Other _____

Duration of pain:

_____years _____ months
_____ Weeks _____ days

Since the pain started, is the pain:

[ ] getting better? [ ] getting worse? [ ] same?

How often does the pain occur?

[ ] Constant [ ] Several times a day
[ ] Less than daily [ ] Occasionally

Is the pain worse at :

[ ] day time or [ ] night time

Does the pain interfere with your sleep?

[ ] Yes [ ] No

Height: _____ **Weight:** _____

Mark the activities that are affected by your pain:

[ ] Enjoyment of life [ ] Relationships with people
[ ] Household chore [ ] Social interaction
[ ] Normal work
[ ] Walking
[ ] Sleep
[ ] Mood

Is the pain worse at?

[ ] day time or [ ] night time Does the pain interfere with your sleep?

[ ] Yes [ ] No

Current Medications:

Please list all other medications you are currently taking:
Or copy of medications provided [ ]

Medicine	Dose

Are you currently taking any blood-thinners or anticoagulants?

[ ] Yes [ ] No

If Yes, which ones? [ ] Plavix [ ] Coumadin [ ] Love [ ] Aggrenox [ ] Other _____

Diagnostic tests and imaging: Mark all the tests you have had to diagnose your pain: [ ] I have not had any diagnostic tests performed for my current pain complaints.

Diagnostic Test	Body location	Date	Facility
MRI			
CT Scan			
X-Ray			
EMG/ NCV			
Other diagnostic test			

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Pain Medication:
Please list any medications you have tried for **this pain:**

Medication	Helped (Y/N)	Side effects

Interventional pain treatments
Please mark if you tried any of the following for your pain:

Treatment	Year	Level/ Nerve/ Region	Helped (Y/N)
Epidural steroid injections			
Facet injections			
Radio frequency ablations			
Sacroiliac joint injections			
Sympathetic blocks			
Trigger point injections			
Spinal cord stimulator			

Other treatments used for this pain:
Please mark if you tried any of the following for your pain:

Treatment	Year	How long?	Helped (Y/N)	Worsened pain
Physical therapy				
TENS unit				
Massage				
Chiropractor				
Brace				

Other Specialists seen for this pain:
List other specialists including pain management that you have consulted with for this pain:

Name	Date

Have you been discharged from a pain clinic?
[ ] No [ ] Yes
If yes, which clinic were you discharged from and when?
_____

Reason for discharge:
_____

Do you have any drug allergies?
[ ] No known drug allergies

ALLERGY	REACTION

MEDICAL HISTORY	DATE (M0/yr)

PREVIOUS SURGERIES	DATE (Month/year)

Family history	
Father	Mother

Smoking status	
Current smoker ( )	Current nonsmoker ( )

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Patient's Name _____ Date of Birth _____

Financial Responsibility

I fully understand that: Insurance billing is a service provided as a courtesy and that I am at all times financially responsible to APS and/or its affiliated entities for any charges not covered by health care benefits. Payment is due in full at time of service. If I have insurance that APS is contracted with, I will be responsible for any amounts that are not paid by my insurance including co-pays, deductibles, coinsurances and non-covered services. You will be charged a $35.00 fee for any bounced checks. Some insurance companies and health plans may determine that a procedure is not "medically necessary" and may not pay for the service. In this case, I will be responsible for the payment. If my insurance company requires pre-certification or a referral in-order to pay for services provided, it is my responsibility to bring such pre-certification or referral before or at the time of service. If I do not, I understand that I will be financially responsible for the total payment related to such services. If I should default on payment for services, my account may be transferred to an independent collection agency, I may be designated as a credit risk, and for all subsequent visits I will be required to pay for services at the time of registration. It is my responsibility to notify APS of any changes in my health care coverage. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services. If I am in doubt about my coverage it is my responsibility to contact my insurance provider to ascertain benefit levels.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to APS and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by APS, and will constitute a continuing authorization, maintained on file with the APS authorize and allow for direct payment to APS of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by APS.

Authorization to Release Information

I authorize the release of any medical or any other information to my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by APS. A copy of this authorization will be sent to my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by APS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I understand that APS Specialists may use and disclose the patient's personal health information for coordinating the patient's medical care, to handle billing and payment, and to take care of other related health operations. Unless I permit it, in general there will be no other uses and disclosures of my medical information. APS Specialists has provided me a detailed document called the "HIPAA Notice of Privacy Practices". It contains information about how we may use and/or disclose your health information. I understand that I have the right to read the "Notice" before signing this acknowledgement. I acknowledge that I have been offered a copy of this office's notice of privacy practices.

OTHER POLICIES

CONSENT FOR CARE: By signing below, I voluntarily consent to receive medical and health care services provided by APS Specialist physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such service may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend APS unless revoked by me in writing such written notice provided to this clinic. **CONSENT FOR REVIEW OF PRESCRIPTION HISTORY:** By signing below, I also grant permission to APS Specialists to obtain my prescription history from external sources for better coordination of my health care. **CANCELLATION POLICY: Consults and follow up visits** - We have a 24 hour policy to cancel or reschedule your appointment for consults and follow up visits at APS Specialists. You will be charged a $25.00 fee payable at your next appointment if you fail to do so. **Procedures** - We have a 48 hour policy to cancel or reschedule your appointment for procedures at APS Specialists. You will be charged a $50.00 fee payable at your next appointment if you fail to do so. Two no-shows and/or cancellations without required notice may result in your discharge from the clinic. By signing below, I acknowledge I have read and understand the cancellation policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Persons/Organizations Providing / Receiving the Information:

Name_____ Address_____

Telephone #_____ Fax #_____

Authorization covering the period of ____/____/____ to ____/____/____

[ ] I hereby **authorize the release of my complete medical record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)

OR [ ] I hereby **authorize the release of my complete medical record with the exception of the following information**: Mental health records, Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment, other (please specify) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months or longer from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized and furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of Patient or Guardian **Date**

Please Note: There will be a charge when you request for medical records for personal reasons or permanent transfer

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HIPAA RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE MEDICAL PROVIDERS & PERSONNEL OF APS SPECIALISTS TO LEAVE VOICE MESSAGES REGARDING THE FOLLOWING PROTECTED HEALTH INFORMATION:
[ ] Appointment Reminders, Lab / Diagnostic Imaging Results, Treatment and plan of care, Billing

I HEREBY AUTHORIZE MEDICAL PROVIDERS & PERSONNEL OF APS SPECIALISTS TO DISCUSS MY PROTECTED HEALTH INFORMATION WITH:

(Name)_____ (Relationship)_____

I UNDERSTAND THAT CERTAIN INFORMATION CANNOT BE RELEASED WITHOUT SPECIFIC AUTHORIZATION AS REQUIRED BT STATE OR FEDERAL LAW. I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED HEALTH TO THE INDIVIDUAL(S) LISTED ABOVE:

Information regarding the patient's diagnosis and Treatment of HIV/AIDS Psychotherapy notes from a Psychiatrist and/or Psychotherapist, Treatment for alcohol and/or drug abuse reports or and c

Patient Signature: _____

Date: _____

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CONTROLLED SUBSTANCE (NARCOTIC) AGREEMENT

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

The long-term use of such substances as opiates (narcotic analgesics), benzodiazepine tranquilizers, and other sedatives and muscle relaxants are controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder (Psychological dependence/physical dependence) developing or of relapse occurring in a person with a prior addiction.

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

GENERAL

1. All controlled substances must come from the physician and/or physician assistant who's initial appears below or, during his or absence, by the covering physician or physician assistant unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment)
2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies our office must be informed in writing.
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse affects you experience from any of the medications that you take.
4. The use of medications is not designed to completely eliminate the pain, rather the medication is used to significant reduce pain so that the individual may be able to perform many activities of daily living as well as social activities. It is hoped that the use of these medications will improve the quality of life but is not expected that the pain relief will be complete.
5. You may not share, sell, trade, exchange your medications for money, goods, services, etc. or otherwise permit others to have access to these medications. You agree to keep these medications in a secure place.
6. You, the patient, may be subject to voluntary evaluation by psychologists or psychiatrists (at the patient's expense if necessary) before treatment and this will be reevaluated every 3-6 months thereafter while being maintained with opioid/pain therapy.
7. Since the drugs may be hazardous or lethal to a person that is not tolerant to its affects, especially children, elderly and pets, you must keep them out of the reach of such people.
8. Prescriptions and bottles of these medications may be sought by individuals with chemical dependency and should be closely safeguarded. It is expected that your will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. It may be requested by APS (Amara Pain & Spine) provider that original containers of medications be brought into the office at each visit to document compliance and to prevent overuse.
10. I will not attempt to get pain medications from any other health care provider without telling them that I am taking pain medications prescribed by the APS providers.
11. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your health care.
12. Unannounced, random urine or serum toxicology screens and pill counts may be requested by APS provider to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder. **Refusal of such testing may subject you to an abrupt rapid wean schedule in order for the medication to be discontinued or prompt termination from care.**
13. I realize that is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by APS.
14. I will not use any illegal substances (cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of care at APS effective immediately.
15. I will not alter my medication in any way (for example crushing or chewing tablets) or use any other auto-delivery (for example injection on insufflation) other then as prescribed by APS.
16. Long-term agents (MS Contin, Oxycontin, Oramorph, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected, and snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which often times may lead to death.
17. I understand that changing date, quantity or strength of medications or altering a prescription in any way, shape or form is against the law. Forged prescriptions or the provider's signature is also against the law. APS cooperates fully with law enforcement agencies locally as well as the Drug Enforcement Agency (DEA) in regards to infractions involving prescription medications. If there is a law violation this will be reported to the patient's pharmacy, local authorities and DEA.
18. I will discontinue all previously used pain medications, unless told to continue them by APS. I will keep APS informed of all medications I may receive from other physicians. This includes the emergency department at hospitals if being treated. You the patient also agree to inform other treating physicians that you are under controlled substance agreement at APS.
19. I understand that strong medications, which may include opiates and other controlled substances may be described for pain relief. I understand that there are potential risks and side effects with taking any medications, including the risks of addiction. Overdose of opiate medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opiate pain killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.
20. I realize that all medications have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long-term use of substances prescribed.
21. It should be understood that any medical treatment is initially a trial, in that a continued prescription is contingent on evidence of benefit.
22. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
23. I will keep all scheduled appointments with APS. Three or more cancellations with less than 24 hours' notice can result in a termination of my treatment by APS.

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24. **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal.
25. **(Females only)** If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and/or primary care provider and the APS office to inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with the risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking opioids. The child could be physically dependent on the opiates and withdrawal can be life threatening for a baby. If a female of child-bearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with medications from APS.

REFILLS

26. **Prescriptions will not be phoned in after hours, on weekends or holidays. No exceptions.**
27. Timely request for refills of medications are solely the patient's responsibility. You agree to adhere to the APS prescription pick-up policy.
28. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with APS prescriber/physician.
29. The prescribing provider will be the only one to decide when and how the patient is to increase or decrease various pain medications. If the provider decides to discontinue the use of pain medicine, the provider will follow the patient through a tapering off.
30. Early refills will not be given. The patient is responsible for taking the medications as prescribed. No unauthorized increase in medications will be tolerated.
31. Refills will not be made as an "emergency". There is a 4 day minimal request to request medication/prescription refills (please see APS prescription policy).
32. Changes in prescriptions/refills will be made only during scheduled appointments and not via phone, at night, on weekends or holidays. This policy will be strictly adhered to.
33. The patient will sign off on "Prescription Policy" for any prescriptions picked-up from office. This will inform patient of any recent changes regarding APS prescriptions/policies.
34. Renewals are contingent upon keeping scheduled appointments and following the APS prescription policy.
35. I agree that continued refill of medications may be contingent upon compliance with other chronic pain treatment modalities recommended by my doctor/physician assistant and with the program in general.
36. Refills will not be made if "I ran out early" or "I lost my prescription" or "spilled, damaged, misplaced, stolen medication". The patient is responsible for taking the medications in the dose prescribed and for keeping track of the amount remaining.
37. Medications will not be replaced if they are lost, misplaced, or destroyed, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made at the discretion of the APS prescriber/provider. However, there is a fee for prescription replacement. (Please refer to our "Administrative Fee Schedule Sheet")
38. Prescriptions may be issued earlier if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist regarding when prescription(s) is allowed to be refilled.
39. If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived and these authorities may be given full access to our records of control substances administration. (For example, you are obtaining medications from other physicians and/or pharmacies)
40. I understand that I must contact an APS prescriber/provider before taking tranquilizers or prescription sleeping medications. I understand that the combined use of the various drugs, opiates as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease and even death.
41. I understand that one my pain management is optimized, refill of my medications may be transferred to my primary care physician. If I do not have a primary care physician at that time I will have from 1-3 months to find a physician who will take over my care and prescribe my medications.
42. I understand that my medication regimen may be continued for definitive time, as determined by my APS providers. My case may be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my function and quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

WITHDRAWAL SYNDROME / TOLERANCE

43. These drugs should not be stopped abruptly, as an abstinence syndrome ("withdrawal syndrome") will likely develop.
44. I understand that opiate analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms which may occur in 24-48 hours of last dose of opioid therapy. Typically this will last a few days. The withdrawal symptoms are usually self-limited but could in rare cases be life threatening.
45. Potential symptoms: yawning, nausea, vomiting, watery eyes/nose, abdominal cramps, diarrhea, muscle or body aches, sweats, chills, hot/cold flashes, "goose flesh", anxiety, agitation, irritability, insomnia, tremors, "racing heart" (increased or decreased heart rate), sweating, watery eyes, runny nose, anxiety, tremors, achy muscles, hot or cold flashes, craving for the medication.
46. Withdrawal from other medications can also have serious consequences, including the risk of injury or death. I will not discontinue any medication I take regularly without consulting a APS provider or my primary care provider.
47. Tolerance is a condition which can occur with the use of opioid medications. It is defined as a need for a higher opioid dose to maintain the same pain control. Usually tolerance to sedation, euphoria, nausea and vomiting occurs more commonly then tolerance to pain relief. This condition may be controlled by switching to a different opioid medication. Tolerance can also be managed by adding a second different drug to the opioid management. If tolerance to the opioid becomes unmanageable the opioid will be tapered and discontinued. The patient must report significant side effects to each of the medications. For example: over sedation, nausea, vomiting, constipation, confusion, euphoria (high feeling) and dysphoria (down feeling), dizziness, sweating, respiratory depression (slow breathing), stomach upset, quick-sudden-jerky movements of the arms or legs, headaches, weakness, tremors, seizures, dreams, muscular stiffness, hallucinations, disorientation, visual disturbances, insomnia, dry mouth, diarrhea, stomach cramps, taste alteration, flushing of the face, chills, increase or decrease in heart rate, increase or decrease in blood pressure, difficulty in urination, itching, skin rashes, swelling with the skin, irritation, irritability, and sexual dysfunction.
48. It is clearly understood that the use of narcotic medication may result in physical dependence. This condition is common to many drugs including steroids, blood pressure medications, anti-anxiety medications, anti-seizure medications as well as opioids. Physical addiction poses no problem to the individual or to the prescribing provider as long as the individual avoids abrupt continuation of the medication. Medication can be safely discontinued after 2-3 weeks of a slow taper. Treatment of intractable chronic pain problems with the use of opioids is controversial. It is however endorsed by many specialists in the field for pain problems, not treatable my any other methods.
49. Treatment of pain problems with this method is nearly always accomplished by using the "analgesic ladder" (using less potent pain medications first and adding to these, other adjutant medications to achieve a combined affect). Psychological addiction should also be understood as a possible risk to the use of opioid medications. This has been shown to be an infrequent occurrence in patients who have been diagnosed with an organic disease causing chronic pain.

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

COMPLIANCE

51. I understand that phone calls after hours should be for issues such as post procedure, post-surgical complications, significant medication side effects and other urgent matters. For the true medical emergency, "911" should be called and/or emergency department treatment should be sought. For non-emergency matters the clinic should be called during normal business hours. There may be a fee assessment for non-emergent calls being placed outside of the routine clinic hours. This is not billable to your insurance.
52. I understand that the main treatment goal is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor. I understand that through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
53. I agree to fully comply with all aspects of my treatment program, including behavioral, medicine and physical therapy. Failure to do so may lead to discontinuation of my medication and discontinuation from the pain program.
54. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medications and authorize the physicians, my pharmacy and insurers to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion/inappropriate use of my pain medication. I authorize APS to provide a copy of this agreement to my pharmacy, other health care providers, insurance carrier and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies/facilities.
55. My doctor at Amara Pain & Spine (APS), physician/physician assistant/provider agree that this agreement is important to my providers ability to treat my pain effectively and my failure to comply with the agreement may result in the discontinuation of prescribed medications by my provider and termination of the physician/provider/patient relationship.
56. I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by the APS prescribing provider. I understand all the policies regarding the prescribing and use of opioids and other care options. I agree to comply with the APS medication management program. I also agree to random testing and detoxification if further indicated.
57. It is understood that failure to adhere to these policies may result in cessation of therapy with control substance prescribed by this physician/physician assistant or referrals for further specialty assessment.
58. You are informed that you have the right and power to sign and be bound by this agreement, and that you have read, understand and except all of its terms.

The APS physicians/physician assistants understand that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.
Lack of strict adherence to any provision of this agreement by APS in no way invalidates any other provisions of this agreement.
If at any time you are concerned about your medications or side effects of your medication you may call APS at 704-503 9338. The on-call physician or physician assistant or pain care team can also be contacted to receive your message if necessary.

CONSENT FOR CHRONIC OPIOID THERAPY

APS is prescribing opioid medication, sometimes called narcotic analgesics, to me for a diagnosis of pain, the decision was made because my condition is serious or other treatments have not helped my pain.
I am aware that use of such medication has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing, slowing of reflexes or reaction time, physical dependence, tolerance to analgesic, addiction and possibility that the medication will not provide complete pain relief.
I am aware about the possible risks and benefits of other types of treatments that do not involve
The use of opioids. The other treatments discussed included. I will tell my doctor about all other medicines and treatments that I am receiving.
I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or not thinking clearly. I am aware that even if I do not notice it my reflexes and reaction time might still me slowed. Such activities include but are not limited to: using heavy equipment or motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.
I am aware that certain other medications such as nalbuphine (newbain), pentazocine (tallwin), buprenorphine (buprenex), and butorphanol (stadol) may reverse the action of the medication I am using for pain control. Taking any of these other medications while I am taking my pain medication can cause symptoms like a bad flu, cold withdrawal symptoms.
I agree not to take any of these medications and to tell any other physicians that I am taking an opioid as my pain medication and cannot take any of these pain medications listed above. I am aware that addiction is defined as the use of medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life.

I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my prescribing provider my complete and honest personal drug history and that of my family to the best of my knowledge.
I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome.
This means I may have any or all of the following: runny nose, yawning, large pupils, "goose bumps", abdominal pain or cramping, diarrhea, irritability, muscle aches, decrease or increase heart rate, agitation, insomnia, hot or cold hot flashes.
This will occur throughout my body and this is a flu like feeling. I am aware that opiate withdrawal is uncomfortable and typically not life threatening. However, this is dependent on other health issues/concerns.
I am aware that tolerance to analgesics means that I may require more medications to get the same amount of pain relief. I am aware that tolerance to analgesics does not seem to be a big problem from most patients with chronic pain, however it has been seen and may occur in me.

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If it occurs increasing doses may not always help and may cause intractable side effects. Tolerance or failure to respond well to opioids may cause my prescribing provider to choose another form of treatment.

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

(Females only) If I plan to become pregnant or believe that I am have become pregnant while taking this medication, I will immediately call my obstetric doctor and/or primary care provider and the APS office to inform them. I am aware that, should I care a baby to delivery while taking these medications, the baby will be physically dependent upon opioids.

I am aware that the u se of opioids is not generally associated with the risk of birth defects. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking opioids.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily, I give my consent for the treatment for my pain with opioid pain medicines. I have also read and signed the comprehennive Controlled Substance Agreement as well and am aware of the many potential risks versus benefits.

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

Patient Name: _____

Patient Signature: _____

Date of Birth: ____/____/____

Prescribing Provider: _____