Workers' Compensation

206 E. Jericho Turnpike, Huntington Station, NY 11746

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Patient Personal Information **Date:**

Marital Status: ☐ Single ☐ Married ☐ Widowed

Sex: ☐ Male ☐ Female

Name: ________________________________

Address: ______________________________

City: ___________________ State: ______ Zip: ______

Email Address:__________________________________

Employer:_______________________________________

Address: ____________________________________

Phone: _____________________________________

Home Phone: ________________

Work Phone: ________________

Date of Birth: ________________

Pharmacy:____________________

SS #: _________________________

Primary Care Physician: _______________________

Address/Phone: __________________________

Referring Doctor: ______________________________

Primary Insurance Company:

Address: __________________ City: ______________ State: _____________ Zip: ___________________

Insured's Name: ________________________ Date of Birth: ________________ SSN#: ________________

Identification #: ________________________ Group ID: ________________

Relationship to Patient: ________________________ Employer: ____

Secondary Insurance Company:

Address: ____ City: ___________________ State: ___________ Zip: _____________

Insured's Name: __________________________________ Date of Birth: _________________ SSN#: _____________________

Identification#: ___________________________________ Group ID: _____________________

Relationship to Patient: ____________________________ Employer: ____

Accident Information:

Is condition due to an accident? ☐ Yes ☐ No Date: _________________

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other:______________

Assignment and Release:

I hereby authorize the physician(s) of Orthopedic Spine Care of Long Island, PC, to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of claims.

I authorize payment of medical benefits to the physician(s).

Patient or Authorized Signature:____

Physician's Signature:____

In case of denial or termination of benefits, I the undersigned, understand that I am responsible for payment in full for services rendered.

Patient or Authorized Signature:____ **Date:**_______________

Workers' Compensation Registration Form

Referring Physician: ____________________________
Referring MD Phone #: __________________________

Patient Number: ___________________________

Carrier Case #: ____________________________ WCB#: ________________________________

Last Name: _____________________________ First Name: ___________________________

Social Security #: ________________________ Date of Birth: ______________________ Gender: Male Female

Street Address: ____

City: ________________________ State:____________________ Zip: ____________________

Home Phone #: __________________________ Cell Phone #: ______________________ Email: ______________________

Date of injury/illness: ________________________

On the date of injury/illness what was the patient's job title or description: ______________________________________
____

Briefly describe how and where injury occurred: ____
____

Are you presently working? ___Yes ___ No If No when did you stop? ______________________________
If Yes, Check: Regular Duty____ Light Duty_____

If you stopped, when did you return? ____

Employer at time of this injury: ____

Employer Address: ____

Employer Phone #: ____ Contact: __________________________________

Employer's Insurance Carrier: ____

Carriers Address: ____

Adjustor Name and Phone #: ____

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay (MD Name ____) his usual and customary fees for services rendered to the above named claimant in the above identified case. I authorize the provider to release any information necessary to substantiate a claim.

Signature: ____ Date: __________________________________

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

❑ Medical Record from (insert date) ___________________ to (insert date) ___________________

❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

❑ Other: ___________________________________

____

Include: (*Indicate by Initialing*)

________ **Alcohol/Drug Treatment**

________ **Mental Health Information**

________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here ____________ I authorize ____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____ Date: ______________________________

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, Mastercard, Discover and American Express

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim. If we later receive a check from your insurer, and your account is paid in full, we will refund any overpayment to you.

3. We have made prior arrangements with some insurance companies and other health plans to accept an assignment of benefits. We will bill them directly, but you are required to pay your co-insurance and deductible at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. When you receive that payment you will be responsible to forward to us the difference between what was paid by you at the time the service was rendered and what was billed to your insurance carrier.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance.

7. If you miss an appointment without calling 24 hours in advance to cancel that appointment, you will be charged $100, barring any unusual circumstances. This charge is allowed by your insurance carrier and will not be billed to them.

I have read and understand the practice's financial policy and I agree to be bound by these terms. I also understand and agree that such terms may be amended by the practice from time to time.

____

Signature of patient (or responsible party, if minor) **Date**

____

Please print the name of the patient

BP: __________ Pulse: ____________ Date: ______________

PATIENT REGISTRATION FORM

Age: ___________ Height: ___________ Weight___________

Patient Name: ____

Doctor Requesting Consult: ___________________________________
Name/Address: ____

Is there someone you would like to send a report of your visit to?

Name/Address: ____________________________________ Name/Address: ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

History of Present Illness:

Chief Complaint: (Reason for being seen) List detailed symptoms, location and description of pain.
Example: I am having pain in my lower back with radiation down to my knees.

____

____

____

1) When did the present episode of pain (weakness, etc.) begin?_______________________________________
2) What, where and how did this episode start?____
3) Have you ever had anything like this before? If yes, when? How? ___________________________________

Neck/Upper Back

Have you experienced arm and hand numbness/weakness? Yes No
Based on a total of 100%, What percentage of your pain is in your ________% neck vs. ________% arms.

Mid/Lower Back

Have you experienced leg numbness/weakness? Yes No
Based on a total of 100%, What percentage of your pain is in your ________% back vs. ________% legs.

1) What makes the pain worse?

___	sitting	___	standing	___	walking
___	bending forward	___	bending backward	___	coughing

2) What reduces the pain?

___	sitting	___	standing	___	walking
___	medications	___	exercise	___	lying down

Past Medical Treatment:

Have you been treated by another doctor for this injury or complaint?   Yes   No

If Yes, please list the doctors name and location

Name: ______________________________   Address: ______________________________

______________________________   ______________________________

______________________________   ______________________________

Have you had any diagnostic test performed for this problem?

Test	Date (s)	Test	Date (s)
X-Rays		**Bone Scan**	
MRI		**Discogram**	
Myelogram		**CAT Scan**	
Dexascan		**Other**	

What other treatments have you tried for your problem/complaint?

Treatment	Date (s)	Treatment	Date (s)
Physical Therapy		**Chiropractic**	
Accupunture		**Surgery**	
Epidural Steriods		**Pain Management**	
Other			

Past Health History: Please check any of the following:

___ asthma
___ angina
___ diabete
___ stroke
___ cancer
___ anemia
___ Other______________

___ kidney disease
___ arthritis
___ hepatitis
___ tuberculosis
___ thyroid
___ blood clots

___ liver disease
___ heart disease
___ high blood pressure
___ stomach ulcers
___ lung disease
___ seizures

Surgeries, Hospitalization, Serious Injuries

Have you ever had **SPINAL SURGERY**? Please list dates, procedure and surgeon.

____

____

____

Please list other **SURGERIES** that you have had. Please include dates.

____

____

____

Please list all the **MEDICATIONS** you are now taking. (This incudes all prescription, over the counter and herbal medications.)

____

____

____

Do you have **ALLERGIES** to ANY medication? Yes No

If yes, please list:____

____

____

Do you have an **ALLERGY** to latex? Yes No

Do you have an **ALLERGY** to shellfish, iodine or x-ray contrast? Yes No

Family History: Please Check any of the below which apply to your family history

Type	Yes	No	Specify Relationship and Dates
Arthritis			
Cancer			
Heart Disease			
Osteoarthritis			
Back Problems			
Diabetes/Thyroid			
Neurologic Disease			
Scoliosis			
High Blood Pressure			

Work History

Occupation: ____

Employer Name/Address ____

____

____

Are you presently working? Yes No

____full time ____ time ____unable to work

____on disability ____unemployed ____retired

How many days of work have you missed in the past year due to your spine problem? ___________

Social History

- Education: (Grade School Middle School High School College Graduate Student)
- Marital Status: (Single Married Widow Divorced)
- Do you smoke? ____Yes _____No If yes,_______Pack(s)/day. How many years?__________
- Do you drink alcoholic beverages? ____Yes ____No How much?______
- Do you now, or have you ever, taken illicit intravenous drugs? ____Yes ____No

Review of Systems: **(Please check all symptoms you have experienced in the past 2 months.)**

A. General: ____fever/chills ____weight loss ____other:________________________

B. Eyes: ____vision loss ____glasses/contacts ____other:________________________

C. ENT: ____hearing loss ____dentures ____other:________________________

D. Cardiac: ____chest pain ____palpitations ____other:________________________

E. Respiratory: ____shortness of breath ____cough
____wheezing ____other:______________________

F. GI: ____bowel dysfunction (incontinence) ____nausea/vomiting
____rectal bleeding ____other:_______________________

G. GU: ____bladder dysfunction (incontinence) ____frequency
____painful voiding ____other:_______________________

H. Musculoskeletal: ____joint pain ____joint swelling
____morning stiffness ____other:_______________________

I. Skin: ____rashes ____lesions
____itching ____other:_______________________

J. Neuro: ____balance difficulties ____seizure
____headache ____other:____________________

K. Psych: ____depression ____anxiety
____mania ____other:____________________

L. Hematologic/Lymphatic: ____bleeding tendency ____bruising
____swollen glands ____other:____________________

M. Allergies/Immunologic: ____decreased immunity ____frequent infection
____other:____________________

My signature signifies that I have read, answered and understand the above information to be true and accurate.

Patient/Guardian signature: ____

Physician use Only: (Comments/Notes)

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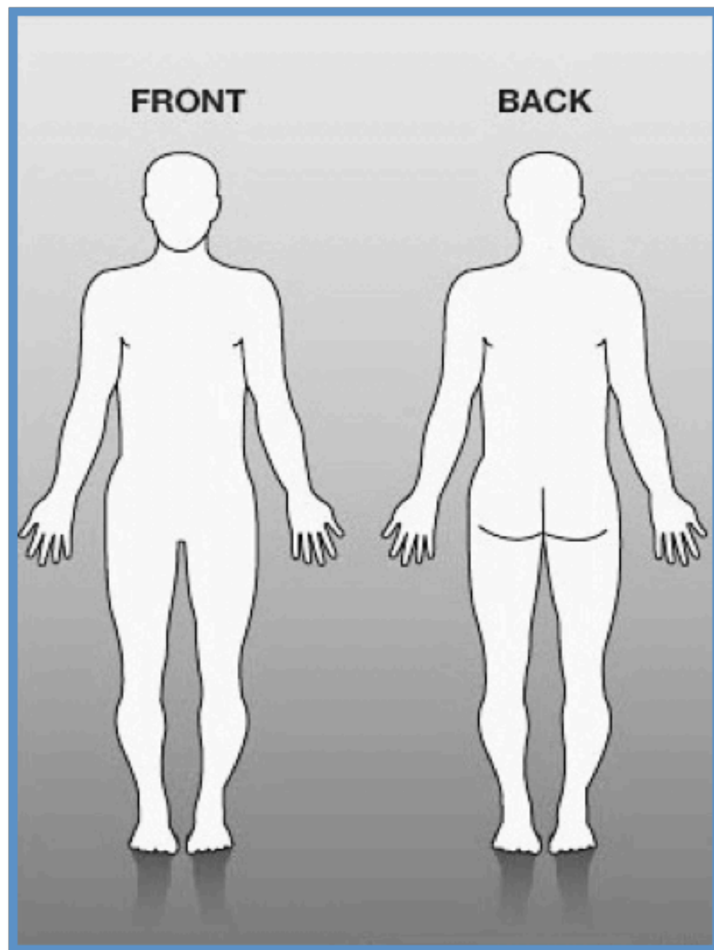
Patient Name:		Date:	

Where Is Your Pain Located Now?

Mark the areas on the body where you feel the described sensations. Please use appropriate symbols. Mark the areas of radiation. Include all affected areas. Please draw in your face.

Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	0000	=======	xxxx	////



Please Initial Appropriate Level:

DOWNSTATE CENTRALIZED MAILING (for New York City, Hempstead, Hauppauge & Peekskill Districts) PO Box 5205 Binghamton, NY 13902-5205 NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552	100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ❑WCB ❑DB ❑Discrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

____, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

____.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

______________________________ ____________________
Claimant's Signature (ink only) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

Employee Claim C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled on on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): ______________________

A: YOUR INFORMATION (Employee)

1. Name: ____________________ (First, MI, Last) 2. Date of Birth: ___/___/_____
3. Mailing address: ____________________ (Number and Street/PO Box, City, State, Zip Code)
4. Social Security Number: __________ 5. Phone Number: (   ) ________ Gender: ☐ Male ☐ Female

Do you speak English? ☐ Yes ☐ No If no, what language do you speak? __________

B. YOUR EMPLOYER(S)

1. Employer when injured: ____________________ 2. Phone Number: (   ) ________
3. Your work address: ____________________ (Number and Street, City, State, Zip Code)
4. Date you were hired: ___/___/_____ 5. Your supervisor's name: __________
6. List names/addresses of any other employer(s) at the time of your injury/illness: __________
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? __________
2. What types of activities did you normally perform at work? __________
3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: __________
4. What was your gross pay (before taxes) per pay period? __________ 5. How often were you paid? __________
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: __________

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ___/___/_____ 2. Time of Injury: ________ ☐ AM ☐ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) __________
4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? __________
5. What were you doing when you were injured or became ill (e.g. unloading a truck, typing a report) __________
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) __________
7. Explain fully the nature of your injury/illness; list the body parts affected (e.g., twisted left ankle and cut to forehead): __________

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

YOUR NAME: ______________________________ DATE OF INJURY/ILLNESS: ___/___/___
First MI Last

D. YOUR INJURY OR ILLNESS continued

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? ________

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
 If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): ________
 If your vehicle was involved, give name and address of your motor vehicle insurance carrier: ________

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
 If yes, notice was given to: ________ ☐ Orally ☐ in writing Date notice given: ___/___/___

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: ________

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ___/___/___ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ___/___/___ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? ________ How often are you paid? ________

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ___/___/___ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
 ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
 Name and address where you were first treated: ________
 ________ Phone Number: ( ) ________
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
 Give the name and address of the doctor(s) treating you for this injury/illness: ________
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
 If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM**
6. Was the previous injury/illness work related? ☐ Yes ☐ No
 If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: ________ Print Name: ________ Date: ___/___/___

On behalf of Employee: ________ Print Name: ________ Date: ___/___/___

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): ________ Date: ___/___/___

Print Name: ________ Title: ________

ID No., if any: **R**________ If Licensed Representative, License No.: ________ Expiration Date: ___/___/___

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Patient Contract for Using Opioid Pain Medication in Pain

This is an agreement between ______________________________ (the patient) and Orthopedic Spine Care of Long Island (OSCLI) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of pain.

Opioid and Controlled Substances Agreement and Informed Consent:
Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to morphine (e.g. MS Contin, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), Hydromorphone (dilaudid), Hydrocodone (e.g. Vicodin,Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinel), etc.

Side Effects & Risks:
Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution:
Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stable dose of these medications are obtained. Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary. If decision is made to terminate opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercise to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea…)

The following conditions must be followed and agreed upon as long as the patient is receiving treatment at OSCLI. Noncompliance with any one of these conditions may result in discharge from the practice.

1. OSCLI must be the only source for the medications that were reviewed above. The patient may not obtain these medicines from any other source or physician except when it is explicitly allowed and approved by your OSCLI provider.

2. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.

3. The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by an OSCLI physician.

4. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to the OSCLI provider. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify OSCLI.

5. **<u>Lost or stolen prescriptions or medications will NOT be replaced</u>**. It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to OSCLI.

6. To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommended appointments.

7. **<u>Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.</u>**

8. OSCLI has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.

9. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at OSCLI.

10. **<u>The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.</u>**

11. The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law.

12. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.

13. **<u>Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test it will result in discharge.</u>** The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician.

I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from OSCLI.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

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Patient Signature   Date

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Doctor Signature   Date