Inclusive Wellness
& Rehabilitation

(phone) 832-649-7919
(fax) 888-812-4235
6550 Mapleridge, #115
Houston, Texas 77081
www.inclusiveclinics.com

Welcome to Inclusive Wellness & Rehabilitation

At Inclusive Wellness & Rehabilitation, PLLC, we appreciate the impact that pain has on the quality of your life. We utilize a team approach to accomplish pain reduction, pain management and return to activity.

Our team includes:

- Ronald A. Green, M.D., Medical Director – Rehabilitation and Occupational Health
- Chau Khuu, M.D. – Board Certified in Anesthesiology
- Physical therapists and support staff

Pain is rarely treated effectively by any single mode of treatment alone. For that reason your treatment at Inclusive Wellness & Rehabilitation will most likely include medication management along with one or more of the following: physical therapy, psychological counseling, nerve block procedures and education.

This is best accomplished by professionals who can work together to meet your needs. For this reason you must let your Inclusive Wellnes & Rehabilitation physician know before you seek any pain management services from another provider while under our care.

Psychology

The role of psychology in our program is to help you cope with the impact that living with chronic pain has on your life; it is not to question the reality of your pain. We believe that being in pain, especially over a long period of time, does affect your stress level, relationships, sleep and the ability to do things which are meaningful to you. Also, untreated depression or anxiety can make managing your pain more difficult. Successful treatment involves addressing all of these issues so that we can best improve your quality of life.

Physical Therapy

The goal of physical therapy is to address specific structural and functional problems and to increase your overall activity level. You may have had physical therapy before with little benefit or even an increase in pain. Our physical therapy staff works only with pain management patients. As pain management leaders, we have unique approaches to helping patients break the cycle of pain and inactivity. If physical therapy is ordered for you, you will be expected to attend at least 80% of your appointments. Failure to do so can result in discharge from both therapy and medical services.

Disability Forms and Letters

Our goal is to restore you to your highest level of function and, when necessary, to assist you with the completion of forms or letters in a timely manner. Our requirements for the completion of disability forms or letters are listed below:

- There will be a charge that must be paid prior to the completion of the form/letter. This charge ranges from $15.00 to $400.00 depending on the complexity of the request. The charge for most forms is $25.00.
- Ten working days will be required for the completion of the form/letter.
- The completion of some forms/letters may require an office visit if additional assessment is required.
- We reserve the right to refuse to complete a form if it requests information that we do not have as a part of your treatment with us.

Next Steps in the New Patient Registration Process

Following this letter you will find a packet of information and forms which we need you to review and/or sign before we can see you for your first appointment.

****Please use the New Patient Checklist to make your registration process seamless.****

Once you are under the care of Inclusive Wellness & Rehabilitation, it is essential that you understand the multidisciplinary treatment program planned for you. If you have any questions, please let a member of our staff know so a nurse or our administrator can address your concerns.

Thank you for choosing Inclusive Wellness & Rehabilitation, PLLC.

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New Patient Checklist

Inclusive Wellness & Rehabilitation, PLLC

Did you:

Read the **Welcome Letter**?

Read the **Notice of Privacy Practices?**

Sign and date the **Notice of Privacy Practices Acknowledgement?**

Complete the **Patient Registration Form?**

Complete your **Patient History?**

Complete your **P3 Assessment?**

Complete the **Pain Questionnaire?**

Read, sign and date the **Opioid Consent Management Agreement?**

Read, sign and date the **Assignment of Benefits & Financial Responsibility Policies Form?**

Read, sign and date the **Missed Appointment Policy?**

Read the **Ownership Disclosure Notice?**

Sign and date the **Ownership Disclosure Notice Acknowledgement?**

Your First Appointment

When you attend your first appointment you must bring:

- Any Radiology Films from other physician's offices; this includes MRI or CT scans or X-rays
- All of your completed paperwork (see checklist above)
- Your insurance card
- A photo identification (Driver's License, etc.)
- All of your medications, including any over-the-counter medication you are currently taking as well as herbal supplements
- Your co-pay, if your insurance plan requires one

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NEW PATIENT REGISTRATION FORM

Inclusive Wellness & Rehabilitation, PLLC

PATIENT INFORMATION:

Name: _____Today's Date: _____

SSN:____-____-_____ Sex: _____ DOB: _____Marital Status: _____

Address: _____

Zip Code: _____ City: _____State: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

***Preferred Phone to Confirm Appointments between hours of 8am to 5pm:**

Spouse Name:_____Daytime Ph#:_____

Emergency Contact: _____Daytime Ph#:_____

Referring Physician: _____ Ph#:_____

Primary Care Physician: _____ Ph#_____

When did you last see your PCP doctor? _____

Employer Information Employment Status: *Employed Unemployed Disabled Retired*

Occupation: _____ Employer Name: _____

Employer Address: _____ Ph# _____

If Retired, Date Retired: _____

If Disabled or unemployed, exact date last worked:_____

School Information, if applicable

Are you currently in school? (please circle) *Y / N* *Full-time / Part-time*

School Name: Grade:

GUARANTOR INFORMATION *(the person responsible for the patient's account)*

What is the patient's relationship to the guarantor? *Self Spouse Child Other:*

Guarantor Name: _____ DOB: _____ SSN: _____-_____-_____

Address: _____

Zip Code: _____ City: _____ State:_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Occupation: _____

Employer Name and Address: _____

INSURANCE INFORMATION

Do you have *Medicare Part A?* ___ *Part B?* ___ *Medicare Policy Number*_____

If you have Medicare, do you also have a Medigap policy or other supplemental coverage? *Yes / No*

Do you have MEDICAID? *Yes / No Medicaid Policy Number* _____

(Medicaid card MUST be presented to Front Desk when you check in)

Is this a ***Worker's Compensation, Auto Accident, Other accident/Injury Claim***? (Circle if app.)

If Yes, Date of Accident/Injury: _____

Are you currently involved in or pursuing litigation over these injuries? *Yes / No* (Circle)

If Yes, Attorney Name: _____ Law firm: _____

Attorney Ph#: _____Claim Number/Case Number: _____

PRIMARY INSURANCE INFORMATION – *Insurance card must be provided to front desk*

Insurance Company Name: _____

Claims Mailing Address: _____

Contact Name: _____ Ph#: _____

Policy Holder's Name: _____SS#: _____

Policy Holder's DOB:_____Relationship: _____

Policy Number/ID#: _____ Group #: _____

Group Name/Employer Name: _____

SECONDARY INSURANCE INFORMATION – *Insurance card must be provided to front desk*

**If Medicare is your primary insurance, is this second policy a former employer's group plan? Yes / No*

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

Contact Name: _____ Ph#: _____

Policy Holder's Name:_____SS#: _____

Policy Holder's DOB:_____Relationship: _____

Policy Number/ID#: _____ Group #: _____

Group Name/Employer Name:_____

OTHER INSURANCE INFORMATION – *info must be provided to front desk, if applicable*

Insurance Company or Worker's Compensation Carrier Name: _____

Claims Mailing Address: _____

Contact Name: _____ Ph#: _____

Policy Holder's Name: _____SS#: _____

Policy Holder's DOB:_____Relationship: _____

Policy Number/ID#/Case#: _____Group #:_____

Group Name/Employer Name: _____

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NEW PATIENT REGISTRATION FORM

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HISTORY of PRESENT ILLNESS

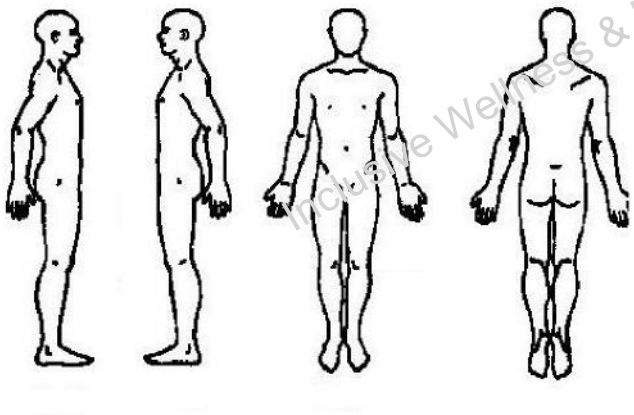
Patient Name (please print): _____ M/F Age _____

Have you ever been to another Pain Center? Yes / No If Yes, where/when: _____

Have you had Physical Therapy before? Yes/No If Yes, where:
When was your last Physical Therapy Appointment? _____
How many visits have you had this year?_____

What is the chief complaint that brings you to the doctor today?

How did these symptoms begin?_____
When did you first start experiencing these symptoms? MM/DD/YY
When did the symptoms progress to the current level of severity?



Please mark on the drawings below all areas where you are feeling pain:

Location: _____

Severity: mild moderate severe

Quality: dull aching stabbing cramping shooting burning throbbing

Duration: Intermittent (stops & starts)
Persistent (all the time)

Pain worse in: morning afternoon evening

Context:

Modifying Factors
What makes it better:
What makes it worse:
Associated Symptoms:

Please circle any of and all of the following you are experiencing:
Sadness Depression Less interest in pleasurable activities Appetite/weight change Worthlessness
Sleep disturbance Feeling agitated or slowed down Fatigue Suicidal thoughts Poor concentration
Excessive worry or anxiety/nervousness Irritability/moodiness Restlessness or feeling "keyed up"
Repeated distressing recollections of a traumatic event

Please circle the number that reflects your current level of pain AT REST:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

Please circle the number that reflects your current level of pain PERFORMING EVERYDAY ACTIVITIES:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

Please circle the number that reflects your current level of pain WHEN PERFORMING YOUR JOB:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the best was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the worst was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

When I take my pain medication as prescribed by my physician, my pain on average is:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

HISTORY

I am: Left-handed Right-handed Ambidextrous

Height: _____ Current Weight: _____ Weight one year ago: _____

ALLERGIES:

Do you have a Latex allergy? Yes/No

Please list all allergies and reactions you have:

FAMILY HISTORY: (please circle any of the following that are present in your family members)

Adverse reaction to anesthesia Cancer Chronic Pain Diabetes Mellitus Fibromyalgia Heart Disease Hypertension Lung disease Mental illness Migraines Rheumatoid Arthritis Seizure Disorder Stroke

Please complete the following:

	Age if Living	State of Health if Living	Age at Death	Current Illness or Cause of Death
Father		Good Fair Poor		
Mother		Good Fair Poor		

Siblings: Number Living _____ Number Deceased

PAST MEDICAL: (please circle any of the following for which you have ever received treatment)

Alcohol abuse Anemia Arthritis Anxiety Disorder Asthma Bleeding disorders
Cancer (type: _____) Coagulopathy Congestive heart failure COPD
Coronary Artery Disease CVA (stroke) Depression Diabetes Drug dependence Gastric ulcer
Hiatal Hernia Hypercholesterolemia General anesthesia-complications Heart disease Hepatitis
B Hepatitis C HIV Hypercoagulopathy Hypertension Hyperthyroidism Hypothyroidism
Kidney disease Liver disease Obstructive Sleep Apnea Postmenopausal Osteoporosis
Psoriasis Psychological trauma Seizure disorder Sexually transmitted disease Thrombophlebitis
Transient Cerebral Ischemia Tuberculosis Urinary Tract Infection Spinal Fusion
Head injury Spinal Cord injury

Are you currently on a blood thinner? Yes / No Which? Coumadin Lovenox Heparin

I have had (or a family member has had) a problem under anesthesia Yes / No
(e.g. prolonged paralysis, awareness, malignant hyperthermia)

Immunizations: (date received) Tetanus: _____ Hepatitis: _____ TB test: _____

Females: Last menstrual period _____ Are you or could you be pregnant? Yes / No
Are your periods regular? Yes / No / n/a Hysterectomy? Yes / No Birth Control Pills? Yes / No

Males: Sexual or erectile dysfunction? Yes / No

Hospitalizations: (please list all major illnesses with diagnosis and year)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Surgeries: (please list all surgeries and type along with year performed)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

When and where have you had any of the following: (list results, if known)

MRI(s): _____

CT(s): _____

X-ray(s): _____

SOCIAL HISTORY: (please circle)

Race: White African American Hispanic Indian Asian Other

Language: English Spanish Other: _____

Marital Status: Single Married Divorced Widowed

I currently live in a: House Apartment Mobile Home Retirement Center

Education:
Some High School (Grade_____) High School Graduate Some College
College Graduate Masters Doctorate

Annual Household Income:
less than $10,000 $10,0001 to $20,000 $20,001 to $40,000 $40,001 to $100,000 **$100,001+**

Job History:
do not work work less than 20 hrs/week work 20-40 hrs/wk work 40hrs or more/week retired
disability applying for disability missed work due to pain no missed work due to pain

JOB HISTORY
Job Title: _____ Years in current position:
Prior Job: _____ Years in that position:

Has your problem that brought you to the Center caused you to change jobs? Yes / No
If you are currently NOT WORKING what was the exact date you last worked: _____
If you are disabled, what year were you declared disabled? _____ By whom?
If appropriate, please circle the level of work your job demands:

Physical demands:	**Sedentary**	**Light**	**Medium**	**Medium Heavy**	**Heavy**	**Very Heavy**
Occasional (0-33%):	10 lbs	20 lbs	50 lbs	75 lbs	100 lbs	over 100 lbs
Frequent (34-66%):	0 lbs	10 lbs	20 lbs	35 lbs	50 lbs	over 50 lbs
Constant (67-100%):	0 lbs	0 lbs	10 lb	15 lbs	20 lbs	over 20 lbs

Tobacco Use:
Do you smoke? Yes / No How many packs per day? _____ Did you ever smoke? Yes / No
Do any of your immediate relatives smoke? Yes / No

Alcohol Use:
How many drinks do you have per week? _____
Have you every been treated for alcohol dependency? Yes / No
Do any of your immediate relatives have or had an alcohol problem? Yes / No

Substance Abuse:
Do you currently use: marijuana, cocaine, crack, ecstacy, methamphetamines,
any other: _____drugs off the street? Yes / No
Have you in the past used any of the above? Yes / No
Do any of your first degree relatives have a substance abuse problem? Yes / No
Have you ever been treated for substance abuse? Yes / No

Caffeine Use:
How many caffeinated beverages do you drink per day?

MEDICATION HISTORY

Please list all current pain medication with mg doses and frequency (times taken per day):

1. _____
2. _____
3. _____

Please list all other medication taken including over the counter, weight loss and nutraceuticals:

1. _____
2. _____
3. _____

Please identify which of the following medications have been tried in the past by checking the appropriate box. (Do not check any drug never taken)

	Helpful?			Helpful?			Helpful?	
NSAID	Y	N	**Muscle Relaxant**	Y	N	**Anticonvulsant**	Y	N
Motrin			Skelaxin			Neurontin		
Lodine			Norflex			Lamictal		
Naprosyn			Soma			Topamax		
Relafen			Robaxin			Depakote		
Indocin			Flexeril			Tegretol		
Celebrex			Zanaflex			Dilantin		
Mobic			Valium			Lyrica		
Opioid (narcotic			**Others**			**Antidepressant**		
Darvocet			Stadol			Elavil		
Percocet			Talwin			Pamelor		
Lortab/Vicodin			Fioricet			Doxepin		
Norco/Zydone			Ultram			Tofranil		
Duragesic			Zostrix			Desyrel		
Dilaudid			Ketamine Gel			Wellbutrin		
Oxycontin			Lidoderm			Anafranil		
MS Contin			Imitrex			Luvox		
MS IR			Amerge			Zoloft		
Kadian			DHEA			Remeron		
Levorphanol			Guaifenesin			Paxil		
Methadone			Dextromethorhan			Prozac		
Actiq			Steroids			Serzone		
			Suboxone			Effexor		
						Respiradol		
						Zyprexa		
						Cymbalta		

REVIEW OF SYSTEMS – (please indicate if you have any of the following conditions or symptoms, circle all that apply)

General Health: Chills Fatigue Fever Night Sweats Weight gain >10lbs Weight loss >10lbs

Skin: Change in wart/mole Dryness Excessive Sweating Hair Loss Nail Changes New Lesions Rash Skin color changes

HEENT: Blurred vision Head injury Double vision Visual loss Hearing loss Ringing in ears Vertigo Nose bleed Sinus Pain Bleeding gums Hoarseness

Neck: Neck mass Neck stiffness Swollen glands

Respiratory: Cough Decreased exercise tolerance Snoring Difficulty breathing Hemoptysis Wheezing

Breast: Breast Mass Breast Pain Nipple discharge Skin changes

Cardiovascular: Chest pain Calf cramps Fainting/blacking out Irregular heart beat Difficulty breathing lying down Shortness of breath Swelling of extremities

Gastrointestinal: Abdominal pain Black tarry stool Bloody stool Change in bowel habits Constipation Diarrhea Difficulty swallowing Heartburn Jaundice Nausea Rectal Bleeding Vomiting Vomiting blood

Musculoskeletal: Joint pain Joint Stiffness Joint swelling Muscle atrophy Muscle weakness

Neurological: Decreased memory Difficulty speaking Dizziness Headaches Incontinence stool Incoordination Loss of consciousness Seizures Stroke Unsteadiness

Psychiatric: Anxiety Change in sleep pattern Depression Hallucinations Mood changes Panic attacks Suicidal ideation History of abuse

Endocrine: Cold Intolerance Excessive Thirst Excessive Urination Hair changes Heat Intolerance Hot flashes Libido change Sexual dysfunction Thyroid problems

Hematology: Abnormal bleeding Anemia Blood clots Easy bruising Prolonged bleeding

Other Medical Problems:

Information Provided by: _____ Date:

To be completed by Inclusive Wellness & Rehabilitation, PLLC:

This record of the patient's chief complaint, past medical, surgical, medication, allergies, social, family history and review of systems has been reviewed by me. This information is an adjunct to any dictated information and is to be considered a permanent part of my consultation and medical record for this patient.

Reviewed by: _____ Date:

INCLUSIVE WELLNESS & REHABILITATION – P3 Assessment

PATIENT NAME: _____

INSTRUCTIONS: The purpose of the P-3 is to assess your emotional functioning. The information obtained from this assessment will help your health care provider design a treatment program for you. If you have any questions, please ask your health care provider.

The P-3 consists of 44 groups of statements. Each group has three choices (1, 2, or 3). Read each group of statements carefully. **Choose the ONE statement in each group that best describes how you have been feeling LATELY, including TODAY.** Be sure to read all of the statements in each group before making your choice. **Then circle the number next to the statement you choose (1, 2, or 3).** Do not leave any groups blank. If none of the statements describes exactly how you feel, choose the statement that comes closest to describing how you feel. If you decide to change an answer, please draw an X through your original answer and then circle your new answer (1, 2, or 3).

(1) 1. I usually sleep well.
2. I have some trouble with sleep.
3. I have a lot of trouble with sleep.

(2) 1. I am a calm person.
2. I am probably more nervous than most people.
3. I often feel so nervous and on edge that I am miserable.

(3) 1. Sometimes I think bad or evil thoughts about people.
2. I always think only the very best about most people.
3. I always think only the very best about all people.

(4) 1. I can do my work and chores around the house.
2. With help I can do my work and chores around the house.
3. I can no longer do my work and chores around the house.

(5) 1. I have no more pain problems than most people.
2. I seem to have more pain problems than others.
3. My life is spent in pain.

(6) 1. I wake feeling pretty good most mornings.
2. I wake feeling tired many mornings.
3. I wake with pain and feeling tired most mornings.

(7) 1. I will sometimes tell people what I think they want to hear rather than the hard truth.
2. I will occasionally tell a lie.
3. I never tell a lie.

(8) 1. People can count on me because I get things done.
2. I sometimes have trouble completing tasks.
3. Much of the time I feel useless to myself and others.

(9) 1. My memory is fine.
2. My memory is not as good as it used to be.
3. I have serious trouble remembering things.

(10) 1. My general health is as good as most people's.
2. Most people seem to be in better general health than I am.
3. I have some serious health problems.

(11) 1. I am a happy person.
2. I don't seem to be as happy as most people.
3. I am not happy.

(12) 1. I get things done and on time.
2. I must sometimes struggle to keep my concentration.
3. I seem to have trouble completing tasks because I keep getting sidetracked.

(13) 1. Most of the time I feel pretty good.
2. I seem to tire easier than most people.
3. I feel weak and tired much of the time.

(14) 1. There are several people in my life who treat me unfairly.
2. Some people seem to treat me unfairly.
3. Many people seem to treat me unfairly.

(15) 1. I am interested in outside activities and other people.
2. I have little interest in outside activities and other people.
3. I have no interest in outside activities and other people.

(16) 1. I am usually at peace with myself and others.
2. I seem to get angry more than most people.
3. I feel angry with somebody or something much of the time.

(17) 1. I seldom have a headache.
2. I have more headaches than most people.
3. I seem to have a headache much of the time.

(18) 1. I trust some people but not others.
2. I trust only a very few people.
3. I believe that most people are only out for themselves and don't care about others.

(19) 1. I am comfortable enough in a group of people.
2. In a group of people I sometimes feel a little nervous.
3. In a group of people I often feel like I don't really belong.

(20) 1. It takes a lot to get me upset.
2. I get upset easier than I used to.
3. It seems like I stay upset much of the time.

(21) 1. It takes a lot before I get tired.
2. I tire easily.
3. I stay tired most of the time.

(22) 1. I have no trouble making decisions.
2. Sometimes I struggle making decisions.
3. I now have more trouble making decisions than I used to.

(23) 1. My mind is usually relaxed.
2. Even when I am still, my mind seems to be racing.
3. It is sometimes impossible to get my mind to relax.

(24) 1. My neck and shoulders feel normal.
2. My neck and shoulders feel tight.
3. My neck and shoulders hurt.

(25) 1. No matter what the problem, I believe there is always hope.
2. Hoping for things to get better is beginning to be a struggle for me.
3. Most of the time I feel hopeless that my condition will improve.

(26) 1. I seldom say something in anger that I later wish I hadn't.
2. Sometimes I say something in anger that I later wish I hadn't.
3. I frequently say things in anger that I later wish I hadn't.

(27) 1. My stomach gives me very little trouble.
2. I seem to have more stomach trouble than most people.
3. My stomach causes me lots of problems.

(28) 1. I enjoy being around other people.
2. I can mix with others but I would rather be alone.
3. I avoid having to be around others.

(29) 1. The muscles in my body usually feel loose and relaxed.
2. The muscles in my body often feel tight.
3. The muscles in my body feel painfully tight.

(30) 1. I seldom have neck or back pain.
2. I will sometimes have neck or back pain.
3. My neck or back seems to hurt most of the time.

(31) 1. I am physically able to do some things but not others.
2. I am not physically able to do most things.
3. I am not physically able to do anything.

(32) 1. I look forward to the future.
2. Things must improve before I will really look forward to the future.
3. My future seems hopeless.

(33) 1. I seldom feel nervous.
2. I frequently feel nervous.
3. I feel nervous most of the time.

(34) 1. I believe that most back problems go away and don't return.
2. I believe that most back problems may go away but are likely to return.
3. I believe that once you have a bad back you will probably always have trouble with it.

(35) 1. I seldom worry about anything.
2. I worry too much.
3. I worry over almost everything.

(36) 1. I feel pretty calm and relaxed.
2. I am probably more tense and uptight than I should be.
3. Sometimes I feel like I am about to lose my mind.

(37) 1. Most of the time my head feels clear.
2. Most of the time my head feels cloudy and dull.
3. I sometimes start sweating and trembling for no known reason.

(38) 1. I have had my fair share of problems.
2. I have had more than my share of problems.
3. Recently it seems like my life is filled with problems.

(39) 1. My blood pressure and heart are in good shape.
2. I have had some problems with my blood pressure.
3. My heart often seems to beat too hard and fast.

(40) 1. I am almost always happy.
2. I am sometimes happy and sometimes sad.
3. I am almost always sad.

(41) 1. My arms and legs feel fine.
2. I sometimes have pain in my hand or foot.
3. Sometimes my entire arm or leg feels numb.

(42) 1. I live a good life.
2. Except for too many problems, my life is pretty good.
3. My life is in a rut.

(43) 1. I am basically satisfied with my life at present.
2. I have some big regrets in my life.
3. I am not satisfied with my life at present.

(44) 1. I am a useful person.
2. I am not as useful to others as I used to be.
3. I sometimes think that everybody would be better off if I were dead.

INCLUSIVE WELLNESS & REHABILITATION **– Pain Questionnaire**

PATIENT NAME:

This questionnaire has been designed to give us information on how your injury or condition currently affects your ability to manage in everyday life. Please answer every question by selecting the answer that best describes your condition. Check the box next to that answer. If you cannot find an answer that exactly describes your condition, choose the answer that most closely fits.

	SECTION 1 – PERSONAL CARE		**SECTION 8 – STANDING**
	I can look after myself without causing extra pain.		I can stand as long as I want without pain.
	I can look after myself normally, but it causes extra pain.		I have some pain on standing but it does not increase with time.
	It is painful to look after myself but I am slow and careful.		I can't stand for longer than 1 hour without increasing pain.
	I need some help but manage most of my personal care.		I can't stand for longer than V2 hour without increasing pain.
	I need help every day in most aspects of self care.		I can't stand for longer than 10 minutes without increasing pain.
	I do not get dressed, I wash with difficulty, and stay in bed.		I avoid standing because it increases my pain immediately.
	SECTION 2 – LIFTING		**SECTION 9 – SLEEPING**
	I can lift heavy weights without extra pain.		I have no trouble sleeping.
	I can lift heavy weights but it causes extra pain.		My sleep is slightly disturbed (less than 1 hour sleepless)
	Pain prevents me from lifting heavy weights off the floor but I manage if they are conveniently positioned (i.e. on a table)		My sleep is mildly disturbed (1-2 hours sleepless)
	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.		My sleep is moderately disturbed (2-3 hours sleepless)
	I can only lift very light weights at the most.		My sleep is greatly disturbed (3-5 hours sleepless)
	I cannot lift or carry anything at all.		My sleep is completely disturbed (5-7 hours sleepless)
	SECTION 3 – DRIVING		**SECTION 10– RECREATION**
	I can drive my car without pain.		I can do all of my usual recreational activities with no pain.
	I can drive my car as long as I want with slight pain.		I am able to do all or most of my usual recreational activities with some pain.
	I can drive my car as long as I want with moderate pain.		I am able to do most but not all of my recreational activities.
	I can't drive my car as long as I want because of moderate pain.		I am able to do only a few of my recreational activities.
	I can hardly drive at all because of severe pain.		I can hardly do any recreational activities because of pain.
	I can't drive my car at all.		I cannot do any recreational activities at all because of pain.
	SECTION 4 – WALKING		**SECTION 11 – SEX LIFE (If inactive, estimate how it would be)**
	Pain does not prevent me from walking any distance.		My sex life is normal and causes no extra pain.
	Pain prevents me from walking more than 1 mile.		My sex life is normal but increases the degree of pain.
	Pain prevents me from walking more than V2 mile.		My sex life is nearly normal but is very painful.
	Pain prevents me from walking more than 1/4 mile.		My sex life is severely restricted by pain.
	I can only walk using a cane, crutches, or a walker.		My sex life is nearly absent because of pain.
	Pain prevents me from walking at all.		Pain prevents any sex life at all.
	SECTION 5 – READING		**SECTION 12 – HOUSE AND YARD WORK**
	I can read as much as I want with no pain.		I can do house and yard work without extra pain.
	I can read as much as I want with slight pain.		I can do my house and yard work but it causes extra pain.
	I can read as much as I want with moderate pain.		I can do most of my house and yard work but it is very painful.
	I can't read as much as I want because of moderate pain.		I can do most house and yard work with extreme pain.
	I can't read as much as I want because of severe pain.		I can hardly do any house and yard work at all.
	I cannot read at all because of pain.		I cannot do any house and yard work.
	SECTION 6 – SITTING		**SECTION 13 – SOCIAL LIFE**
	I can sit in a chair as long as I like.		My social life is normal and gives me no extra pain.
	I can only sit in my favorite chair as long as I like.		My social life is normal but increases the degree of pain.
	Pain prevents me from sitting more than 1 hour.		Pain has no significant effect except for limiting energetic interests.
	Pain prevents me from sitting more than V2 hour.		Pain has restricted my social life to my home.
	Pain prevents me from sitting more than 10 minutes.		I have hardly any social life because of pain.
	I avoid sitting because it increases my pain.		
	SECTION 7 – WORK		**SECTION 14 – TRAVELING**
	I can do as much work as I want to.		I can travel anywhere without extra pain.
	I can only do my usual work but no more.		I can travel anywhere but it gives me extra pain.
	I can do most of my usual work but no more.		Pain is severe but I manage journeys over two hours.
	I cannot do my usual work.		Pain restricts me to journeys of less than 1 hour.
	I can hardly do any work at all.		Pain restricts me to short necessary journeys under 30 min.
	I can't do any work at all.		Pain prevents me from traveling except to the doctor or hospital.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
☑ **Reports for Radiology, Images/Films, MRI, CT Scan, X-rays, Ultrasound**

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Inclusive Wellness & Rehabilitation, PLLC

Address: 6550 Mapleridge, Suite 115

City, State, Zip: Houston, Texas 77081

☐ **Please mail records.**

X **Please fax records.**

Fax: 888-812-4235 **Phone:** 832-649-7919

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

Inclusive Wellness
& Rehabilitation

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Notice of Privacy Practices

Inclusive Wellness & Rehabilitation, PLLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment, or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Protected Health Information is information about you including demographic information that may identify you and that relates to your past, present, or future, physical or mental health condition, and related healthcare services. This notice is divided into three sections and describes the uses and disclosures of your Protected Health Information, your rights as they relate to your Protected Health Information, and our duties as a healthcare provider. We are required to abide by the terms of this notice of Privacy Practices.

Section I – Uses and Disclosures of Your Protected Health Information

Federal law allows this practice to use and disclose your Protected Health Information to carry out treatment, payment, and healthcare operation activities. Your Protected Health Information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care for the purpose of providing healthcare services to you. Your Protected Health Information may also be used and disclosed to obtain payment for your health care services and to support the operation of our practice. The following examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

The use and disclosure of your Protected Health Information for treatment purposes includes uses and disclosures to provide, coordinate, or manage your healthcare. Examples of this would include disclosure of Protected Health Information to other physicians who may be treating you, including physicians who refer you to our practice. Also, Protected Health Information may be provided to a physician or another service provider to whom you have been referred by our practice to insure that individual has the necessary information to diagnose you and provide care. Information will also be disclosed to and received from pharmacies to coordinate and oversee prescription medication management.

Your Protected Health Information will also be used as needed to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for healthcare services that we recommend for you. Examples include determining eligibility or coverage for insurance benefit, reviewing services provided to you for medical necessity, and undertaking utilization review activities. This would include pre-certification or pre-determination of benefits for outpatient surgical procedures.

We may also use and disclose your Protected Health Information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. A specific example of this would be the review of medical records by outside agencies who audit medical records for the purpose of insuring quality care. We may also use a sign-in sheet at the registration desk where you will be asked to sign your name and service you are receiving. We may also call you by name in the waiting room when your physician or service provider is ready to see you. We may use or disclose your Protected Health Information as necessary to contact you to remind you of your appointments.

We will share your Protected Health Information with Third Party "business associates" that perform various activities for our practice. These activities include, but are not limited to, the provision of certain types of patient's specific medical equipment, the maintenance of computer software, and collection activities. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health information, we will have a written contract that contains terms that will protect the privacy of your Protected Health Information.

We may use or disclose your Protected Health Information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

In addition to the uses and disclosures described above that are permitted, as they relate to your treatment, payment for healthcare services, or the operations of this facility, certain other uses or disclosures are permitted or required by law. Specifically, unless you object, we may disclose to a member of your family, a relative, a friend, or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to identify your location or general condition to a family member, a personal representative, or any other person that is responsible for your care. Finally, we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

The following are specific uses and disclosures of your Protected Health Information that may be made without your agreement or authorization as required by law. We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relative requirements of the law.

We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your Protected Health Information if directed by the public health authority to a foreign government agency that is collaborating with the public health authority.

We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition. We may disclose Protected Health Information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and civil rights laws.

We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your Protected Health Information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, a disclosure will be made consistent with the requirements of applicable federal and state laws.

We may disclose your Protected Health Information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance as required.

We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to a court order or administrative tribunal or in certain conditions in response to a subpoena, discovery request, or other lawful process. We may also disclose Protected Health Information so long as applicable legal

requirements are met for police law enforcement purposes. These law enforcement purposes include legal processes, limited information requests for identification and location, those pertaining to victims of a crime, in the event that a crime occurs on the premises of the practice, and in the event of a medical emergency. Consistent with applicable federal and state laws, we may also disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.

When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are armed forces personnel. Please inquire if you have specific questions regarding the disclosure of Protected Health Information as it relates to military service. We may disclose your Protected Health Information to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services.

Your Protected Health Information may be disclosed by us in compliance with Worker's Compensation and laws and other similar legally established programs.

We may also use or disclose your Protected Health Information if you are an inmate of a correctional facility and your physician created or received your Protected Health Information in the course of providing care to you.

In summary, we may use or disclose your Protected Health Information without your authorization for the purposes of providing healthcare services to you (treatment), securing payment for healthcare services, and supporting the operation of this practice. In addition, your Protected Health Information may also be disclosed without your authorization for certain purposes as described above and as required by law. Unless you object, your Protected Health Information can also be disclosed to family members or others involved in your care as described above.

All other uses and disclosures of your Protected Health Information will be made only with your written authorization. You may revoke this authorization at any time in writing except to the extent that your physician or physician's staff has taken an action in response to that authorization.

Section II – Your Rights

You have the right to inspect and receive a copy of your Protected Health Information. This means that you may inspect, in the presence of a staff member, your Protected Health Information as well as request a copy of this information. You may request to inspect or to receive a copy of your Protected Health Information for as long as we maintain that information. This information may include medical and billing records and any other records that your physician and this practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes that are maintained outside of the medical record, information compiled in reasonable anticipation of or in use in a civil, criminal, or administrative action or proceeding, and Protected Health information that is subject to law that prohibits access to that information. Access may be denied if a healthcare provider has determined that access to the record is likely to endanger the life or safety of you or another individual, or cause substantial harm to another individual who is not a healthcare provider mentioned in the record. If access to your medical record is denied, you will be informed in writing of the denial. Certain reasons for denying access to your medical record are reviewable and you may have a right to request that a denial be reviewed. Please contact our Privacy Official if you have questions about access to your medical record, or if you wish to have a denial reviewed. The state approved fee for the copying of medical records will be applied to any request for copies of health information.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose a part of your Protected Health Information for the purposes of treatment, payment, or health care operations. You may also request that a part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this notice of

Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your Protected Health Information, as otherwise permitted by law, your Protected Health Information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by informing any member of our staff of your desire to restrict the use and disclosure of your Protected Health Information. The staff member will complete, with your assistance, a Restricted Disclosure Form, and forward it to the Privacy Official who will obtain the approval of the physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. This means you can ask us to contact you or leave messages at alternative phone numbers or send correspondence to an alternative address. We will accommodate all reasonable requests. We may, however, require you to provide us information as to how payment will be handled, or to specify an alternative address or method of contact. We will not request an explanation of your request from you. Please make this request in writing and ask any member of our staff to forward it to our Privacy Official.

You may have the right to have your physician amend your Protected Health Information. This means you may request that your physician correct information in your medical record that you believe to be inaccurate for as long as that health information is maintained in our practice. We may deny your request for an amendment if the information in question was not created by your physician or a member of the staff at this practice, or if your physician believes the information contained in your medical record is accurate and complete. If we deny your request for an amendment, you have the right to file a Statement of Disagreement with us, and we may prepare a rebuttal to your statement. Both your Statement of Disagreement and our prepared rebuttal, if any, will become part of your Protected Health Information and will be disclosed as part of any permitted or required disclosure. You will receive a copy of any written statement of rebuttal placed into your medical record. Please make any requests for amendment of your Protected Health Information to a member of our staff in writing and ask them to forward it to the Privacy Official.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations, and does not apply to disclosures made in response to a valid authorization signed by you or a personal representative. It also excludes disclosures made to family members or others involved in your care. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. Your right to receive this information is subject to certain exceptions, restrictions, and limitations.

Section III – Our Duties

This practice is required by law to maintain the privacy of Protected Health Information and to provide you with notice of our legal duties and Privacy Practices with respect to Protected Health Information. We must provide to you this written notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all Protected Health Information that we maintain at that time. Upon your request, we will provide you with any revised notice of Privacy Practices. You may obtain a revised notice by calling the office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Official of your complaint. We will not retaliate against you for filing a complaint. Our Privacy Official is the facility administrator and may be contacted at (832) 649-7919. This notice was published and became effective on April 14, 2003.

Inclusive Wellness
& Rehabilitation

(phone) 832-649-7919
(fax) 888-812-4235
6550 Mapleridge, #115
Houston, Texas 77081
www.inclusiveclinics.com

Notice of Privacy Practices Acknowledgement

INCLUSIVE WELLNESS & REHABILITATION, PLLC

I,_____, have received a copy of the Notice of Privacy Practices for Inclusive Wellness & Rehabilitation, PLLC.

_____ _____

Signature Date

Inclusive Wellness
& Rehabilitation

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Assignment of Benefits & Financial Responsibility Policies

INCLUSIVE WELLNESS & REHABILITATION, PLLC

ASSIGNMENT OF BENEFITS

I authorize and direct my insurance carrier, attorney lien settlements, Medicare, Medicaid, and/or medical supplements to pay benefits to Inclusive Wellness & Rehabilitation, PLLC and/or physical rehabilitation services rendered to me, regardless of the carrier's policy concerning this office. If my current policy prohibits direct payment to this office, I hereby also instruct and direct you to make out check to me and mail it to 6550 Mapleridge, Suite 115 Houston, Texas 77081. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original.

My signature affixed here may be kept on file to suffice for any signatures required on the insurance claim forms. In addition, I authorize Inclusive Wellness & Rehabilitation, PLLC to release pertinent information to my insurance carrier, for the sole purpose to file and follow-up on claims to obtain payment for services rendered to me.

PATIENT SIGNAURE:_____ _____ DATE:_____

FINANCIAL RESPONSIBILITY POLICIES

I understand this office will make every effort to obtain payment from the insurance carrier, Medicare, Medicaid, and/or other third party payor. I acknowledge and understand services may be denied for any and all reasons, including, but not limited to, pre-existing conditions, routine, experimental, not reasonable or necessary, trauma, injury or work related, etc.

I acknowledge I am financially responsible for all fees incurred for services rendered regardless of insurance. I acknowledge failure to comply with the financial policies of this practice will place my status at this practice in jeopardy.

Any unpaid balance owed on my account may be assessed at the rate of 1.5 % per month (18% per year). If bills remain unpaid for more than sixty (60) days this practice will proceed with legal action to collect the account**. I understand I will be responsible to pay for any fees incurred for the collection of my bill. This includes, but is not limited to outside collection agency fees, interest charges, attorney fees, and court costs**

IF MY INSURANCE PAYS ME DIRECT, I agree to forward the payment to this office within 10 days of my receipt of payment. I further understand, failure to comply with this policy will place my status at this practice in jeopardy, as well as proceeding with legal action to collect the account. In addition to the balance due, any collection agency fees and/or attorney fees will be assessed to the account.

PATIENT SIGNAURE:_____ _ DATE:_____

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Missed Appointment Policy

INCLUSIVE WELLNESS & REHABILITATION, PLLC

ALL appointments require a 24-hour cancellation notice to avoid a NO SHOW fee.

For a missed appointment or cancellation less than 24 hours scheduled for you with Drs. Ronald Green, MD or Chau Khuu, MD will be charged the full visit cost amount of $350

All other appointments that are not given a 24-hour notice will be charged a fee of $25.00 for a NO SHOW.

This charge is the responsibility of the patient, not the insurance carrier. Cancellation penalties are expected to be paid in full at the time of your next appointment.

All procedure appointments are confirmed 24-hours in advance. We must have a valid daytime phone number for you to confirm these appointments in person. Please advise the office staff of a preferred phone number for appointment confirmations.

I have read and understand the above policy.

Printed Name: _____

Signature: _____ Date:_____

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Oral Opioid (Narcotic) Consent Form and Management Agreement

This agreement between the undersigned (patient) and Ronald A. Green, MD and/or Chau Khuu, MD is to establish clear conditions for the prescription and use of controlled substances and pain medication prescribed by the doctor for the patient. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship. The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the doctor for the patient:

1. Opioid medication may be prescribed for me ONLY by and Ronald A. Green, MD and/or Chau Khuu, MD.
2. I will not solicit nor accept a prescription for opioid medication from any other physician without the prior written consent of one of the above staff.
3. I will take the prescribed medication only at the dose, frequency, and drug as prescribed.
4. I will not, under any circumstance, increase my dose or frequency without my doctor's permission.
5. I will and do consent to periodic drug screening at the doctor's request.
6. I will not use any illegal substances, including marijuana, cocaine, amphetamine, etc.
7. I will not use this medication with any alcohol-containing beverages.
8. I will not share, sell, or trade my medication for money, goods, or services.
9. I will not undergo any pain management procedures or injections without the preceding consent of and Ronald A. Green, MD and/or Chau Khuu, MD. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.
10. I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my medication for a period of time, and may precipitate a re-evaluation of my competence to continue on these medications.
11. I understand that an important part of my pain management program may include non-drug treatment. If I fail to follow-through with my doctor's treatment program, I understand and agree that opioids may be withdrawn.
12. I understand that reduction in the intensity of my pain as well as improvement in my quality of life and function-ability are the desired goals of treatment. Should it become evident to my doctor that these objectives are not being met with the use of opioids, I agree to weaning and discontinuation of narcotic medication.

I understand that the long-term advantages and disadvantages of chronic opioid have yet to scientifically determined and that treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

I understand that all medications have potential side effects. I have been fully informed by the doctor of the potential side effects including, but not limited to: Physical dependence, pseudo-addiction, chemical dependence, addiction, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to organs. A distinct clinical syndrome, "Hyperalgesia Syndrome", has been described in the literature and can result in increased pain from continual and escalated doses of opioid medication. If I take more medication than prescribed, a dangerous situation could result such as coma, organ damage, or even my death.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until my abilities have been properly evaluated and/or my medications have been held for four days.

I agree to waive any applicable privileges or right of privacy or confidentiality with respect to prescription medication and I authorize one of the above staff and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency including the Indiana Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I understand that my physician or nurse practitioner may utilize the INSPECT website to further assess my compliance.

I agree to the following regarding prescription refills: Prescription refills of my medication will be made only during regular office hours, in person, once every month during a scheduled office visit, or more frequently as recommended by my doctor and/or nurse practitioner. Refills will not be made on an emergency basis, nights, weekends, or holidays. I am free to visit an ER or other physician and have them contact my doctor in any emergency situation.

I agree to be evaluated by a psychologist and/or addiction specialist at any time during my treatment at my doctor's request. If, in their opinion, I am not a candidate for further narcotic treatment, I agree to weaning and treatment discontinuation.

(Females only): Narcotics are felt to have minimal risk for development of birth defects. However, if I continue to take these medications throughout pregnancy, my child will be born drug-dependent and need specialized care. I therefore agree that if I plan to become pregnant, or believe I have become pregnant while on these medications, I will immediately notify my obstetrician and Ronald A. Green, MD and/or Chau Khuu, MD. Doctor and patient agree that this agreement is essential to the doctor's ability to treat the patient's pain effectively and that failure of the patient to abide by the terms of this agreement may result in the withdrawal of all prescribed medication by the doctor and the termination of the doctor-patient relationship.

Examples of opioid medication include: Lortab, Fentanyl, Opana, Vicodin, Norco, OxyContin, MS Contin, Percocet, Kadian, Avinza, Tylox, Methadone, Demerol, Dilaudid, Darvocet, Codeine, Subutex, and Suboxone. It is my responsibility to know these and other medications which are opioid compounds which I may be taking.

Acknowledgement

I have read or have had the above form read to me and understand all of it. I have had a chance to have all my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment of my painful condition with opioid medications and any other medications that the physician may prescribe as part of my treatment regimen.

Patient Printed Name: _____

Patient Signature: _____

Doctor Signature:_____

Date:_____

Witness (receipt of copy of agreement): _____