CHESAPEAKE PAIN & WELLNESS

12200 Annapolis Road, Suite #225
Glenn Dale, Maryland 20769
Ph: 301.867.2488
Fax: 301.390.6243

DEMOGRAPHICS

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
SOCIAL SECURITY NUMBER:	SEX:	PREFIX/SUFFIX:
DATE OF BIRTH *(mm/dd/yy)*:	STATUS *(please check one)*: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partner	STUDENT *(please check one)*: ☐No ☐Full Time ☐Part Time
STREET ADDRESS:	CITY/STATE:	ZIP CODE:
HOME PHONE *(include area code)*:	WORK PHONE:	CELL PHONE:

RACE *(please check one)*: ☐White ☐Black/African American ☐Asian ☐Hawaiian/Other Pacific Islander ☐Hispanic/Latino ☐Other Race American Indian/Alaska Native	PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other: _____

EMPLOYER:	JOB TITLE/STATUS:	EMPLOYER ADDRESS:	EMPLOYER PHONE NUMBER:

PREFERRED PHARMACY:	PHARMACY PHONE NUMBER:	EMAIL ADDRESS:

PRIMARY INSURANCE INFORMATION

POLICY NUMBER:	GROUP ID:		EFFECTIVE DATE:
TYPE *(please check one)*: ☐Health ☐Auto ☐Work. Comp. ☐Other	PRIMARY INSURANCE? ☐Yes ☐No	END DATE:	COPAYMENT AMOUNT: Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN:	INSURANCE COMPANY ADDRESS:		PHONE NUMBER:
POLICY HOLDER:	DATE OF BIRTH *(mm/dd/yy)*:		SOCIAL SECURITY NUMBER:

INSURANCE POLICY HOLDER INFORMATION
(If you are not the policy holder, fill out the information below)

ARE YOU THE POLICY HOLDER? ☐Yes ☐No	LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
SSN OF HOLDER:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:	SEX:	MARITUAL STATUS:
HOME ADDRESS:	CITY/STATE:	ZIP CODE:	HOME PHONE:
EMPLOYER:	WORK PHONE:	JOB TITLE:	

SECONDARY INSURANCE

POLICY NUMBER:	GROUP ID:	EFFECTIVE DATE:
TYPE *(please check one)*: ☐Health ☐Auto ☐Work. Comp. ☐Other	ARE YOU THE POLICY HOLDER? ☐Yes ☐No END DATE:	COPAYMENT AMOUNT: Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN:	INSURANCE COMPANY ADDRESS:	PHONE NUMBER:

INSURANCE POLICY HOLDER INFORMATION
(If you are not the policy holder, fill out the information below)

ARE YOU THE POLICY HOLDER? ☐Yes ☐No	LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
SSN OF HOLDER:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:	SEX:	MARITUAL STATUS:
HOME ADDRESS:	CITY/STATE:	ZIP CODE:	HOME PHONE:
EMPLOYER:	WORK PHONE:	JOB TITLE:	

I authorize my insurance benefits to be paid directly to *Chesapeake Pain and Wellness*. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to *Chesapeake Pain and Wellness* or any of its affiliates or agents, lenders, or any third-party servicer acting on behalf of *Chesapeake Pain and Wellness*. I understand that I am responsible for any fees not covered by my insurance provider.

_____

Print Name

_____

Signature

_____

Date

Patient Assessment Form

EXERSIZE: Type of exercise: _____
Days/Week: _____

TOBACCO USE: Do you currently use tobacco products? ☐Yes ☐No
IF YES, how many packs a day? _____ How many years? _____
IF FORMER SMOKER, when did you quit? _____ before you quit, how many packs a day _____ and how many years _____

Do you drink caffeinated beverages? ☐YES ☐NO If yes, how many cups/cans per day? _____

Do you drink alcoholic beverages? ☐YES ☐NO If yes, how many beverages per week? _____
Have you ever felt you should cut down on drinking alcohol? ☐Yes ☐No
Have people annoyed you by criticizing your drinking? ☐Yes ☐No
Have you ever felt bad or guilty about your drinking? ☐Yes ☐No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of your hangover? ☐Yes ☐No

Do you use any illegal drugs? ☐Yes ☐No If yes, how much: _____

Have you ever had, or do you have a substance abuse problem? ☐Yes ☐No

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Are you currently employed? ☐Yes ☐No.

If yes, please complete the following questions:
Your current employer _____
Your current occupation _____
Your usual duties include: _____
Are you involved with Workman's compensation? ☐Yes ☐No
If so, what is the name and phone number of your case worker? _____

If no: are you ☐Disabled ☐Retired How long: _____

Other

Is there any chance you could be pregnant? ☐Yes ☐No If yes, when is your due date? _____

Are you hard of hearing? ☐Yes ☐No

Do you need glasses to read? ☐Yes ☐No

Would you like to have a consult with a dietician to discuss any dietary concerns? ☐Yes ☐No

Are there any religious or cultural factors which may impact your care while in the clinic? ☐Yes ☐No
If yes, please explain _____

Do you, or anyone you know, need information regarding problems of abuse and/or neglect? ☐Yes ☐No

---

What are your realistic goals for treatment of your pain? (check all that apply)
☐To be pain free ☐Help living with pain ☐Reduced pain ☐Increased activity ☐Other_____

Thank you for your time in completing this form.

X _____
Patient Signature

New Patient Information

Please answer every question below as concisely and accurately as possible.

The form may seem lengthy, but it is very important to help us understand your pain complaints. This will help us provide you with the highest level of care.

Primary Care Provider: City & State: Phone Number:

Referring Provider: City & State: Phone Number:

Have you ever been seen or are you currently seeing a Pain Management doctor? ☐Yes ☐No

Pain Doctor's Name Phone Number

List areas of Pain:

1.
2.
3.

When did your pain begin? _____ weeks _____ months _____years

How did your pain start? _____

Does your pain radiate anywhere? (Examples: into arm, leg, chest, and abdomen)

Is the pain: ☐Intermediate ☐Constant

Check the words which best describe your pain:

☐Aching ☐Sharp ☐Gnawing ☐Dull ☐Throbbing

☐Shooting ☐Cramping ☐Tightness ☐Stabbing ☐Tearing ☐Deep

☐Searing ☐Burning ☐Other: _____

Circle the numbers between 0-10 that represents the intensity of your pain:

Key: 0 = No Pain
5 = Interferes with activities
10 = Worst pain imaginable

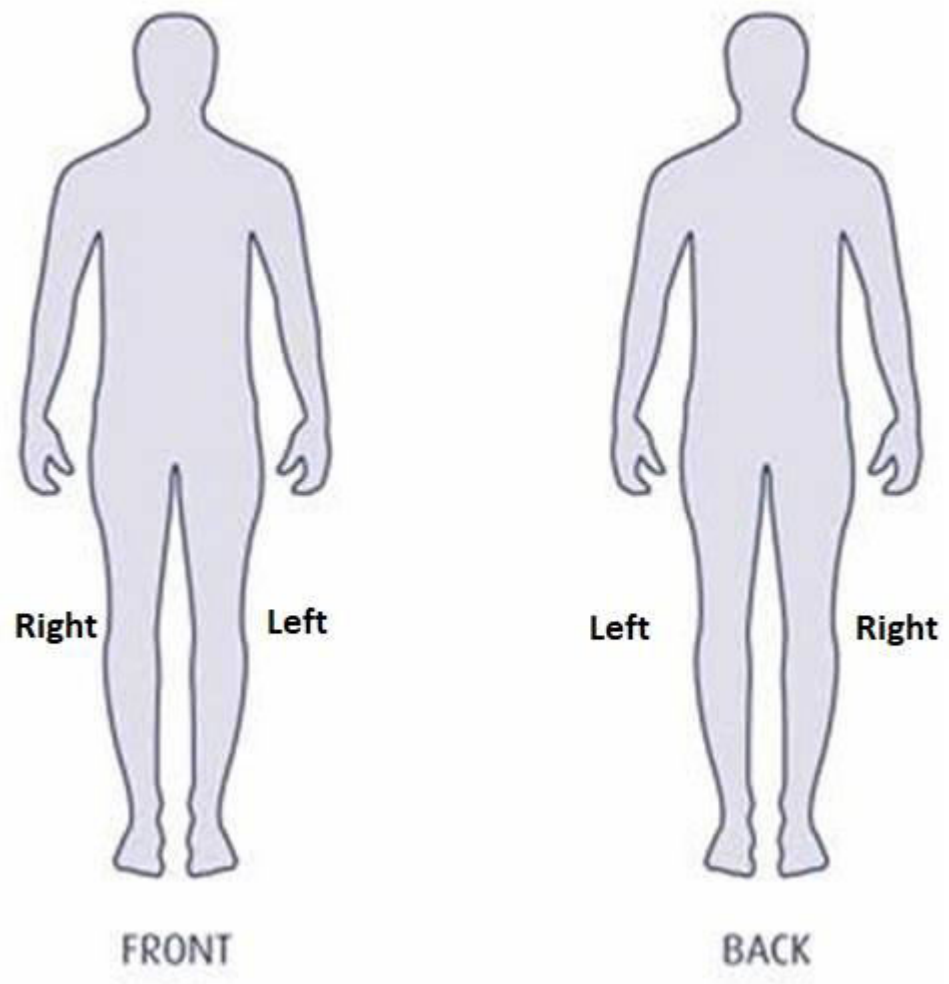
Average pain = 0 1 2 3 4 5 6 7 8 9 10
Worst pain = 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? (please check all that apply)
☐Sitting ☐Standing ☐Walking ☐Lifting ☐Lying Flat ☐Other: _____

What makes your pain better? (please check all that apply)
Nothing Sitting Standing Walking Rest Other: _____

Pain Diagram:

Key: Stabbing = //////// Burning = XXXX Pins and Needles = 0000 Numbness: = = = =
Aching/Throbbing = ^^^^^^ Other = …….



What pain medication have you tried?

Medication	Still Using	Stopped Because
Tylenol	☐	☐
Aspirin	☐	☐
Ibuprofen (Motrin/Advil)	☐	☐
Naprosyn (Aleve)	☐	☐
Toradol (Ketorlac)	☐	☐
Diclofenac (Arthotec)	☐	☐
Flector Patches	☐	☐
Mobic/Meloxicam	☐	☐
Celebrex	☐	☐
Valium	☐	☐
Flexeril/Cyclobenzaprine	☐	☐
Zanaflex	☐	☐
Soma	☐	☐
Neurotoxin/Gabapentin	☐	☐
Lyrica	☐	☐
Cymbalta	☐	☐
Savella	☐	☐
Effexor	☐	☐
Lexapro	☐	☐
Amitriptyline (Elavil)	☐	☐
Nortriptyline (Pamelor)	☐	☐
Lidoderm Patches	☐	☐
Ultram/Tramadol	☐	☐
Ultracet	☐	☐
Darvocet N50 N100	☐	☐
Codeine	☐	☐
Tylenol #2,3 or 4	☐	☐
Hydrocodone 5/ 7.5/ 10	☐	☐
Vicoden 5/ 7.5/ 10	☐	☐
Percocet 2.5/ 5/ 7.5/ 10	☐	☐
Methadone	☐	☐
Morphine	☐	☐
Kadian	☐	☐
Aviza	☐	☐
Embeda	☐	☐
Opana IR	☐	☐
Opana ER	☐	☐
Fentanyl Patches	☐	☐
Actiq Lollipops	☐	☐
Fentora	☐	☐
Oxycodone	☐	☐
Oxycotin	☐	☐
Hydromorphone (Dilaudid)	☐	☐

Please list other pain medications you have tried.

Medications	Still using	Stopped Because
_____	☐	☐_____
_____	☐	☐_____
_____	☐	☐_____

What Treatments have you tried:

Procedure	How long	Effective
Trigger Points	_____	☐ Yes ☐ No
Epidural Steroids	_____	☐ Yes ☐ No
Nerve Blocks	_____	☐ Yes ☐ No
Facet Blocks	_____	☐ Yes ☐ No
Sacro-iliac injections	_____	☐ Yes ☐ No
Spinal Cord Stimulator	_____	☐ Yes ☐ No
Intrathecal Pumps	_____	☐ Yes ☐ No
Physical Therapy	_____	☐ Yes ☐ No
Chiropractor	_____	☐ Yes ☐ No
Aqua therapy	_____	☐ Yes ☐ No
Acupuncture	_____	☐ Yes ☐ No
Traction	_____	☐ Yes ☐ No
Surgery	_____	☐ Yes ☐ No
Durable Medical Equipment	_____	☐ Yes ☐ No
Other	_____	☐ Yes ☐ No

Do you have any allergies to medications? ☐ **Yes** ☐ **No Known Drug Allergies**

If yes, please list your allergies below:

Drug	Reaction
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Are you allergic to iodine or x-ray contrast? ☐ **Yes** ☐ **No**

List ALL current medications you are taking (including prescriptions and over the counter):

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

List ALL Surgeries:

Surgery	Date	Doctor	Hospital
1.			
2.			
3.			
4.			
5.			

List ALL Medical Problems: (Including any diagnosis of anxiety or depression)

Medical Problem	Treating Doctor
1.	
2.	
3.	
4.	
5.	

Family and Social History:

Is your mother	☐ Alive	List major illness _____
	☐ Deceased	Age and cause of death _____
Is your father	☐ Alive	List major illness _____
	☐ Deceased	Age and cause of death _____

Do you have children? ☐ **Yes** ☐ **No**

Son/Daughter	Age	Medical Problems
1.		
2.		
3.		
4.		

Activities and your Pain:

List your hobbies and interest:

1. _____
2. _____
3. _____
4. _____

Does your pain stop you from doing the things you enjoy? ☐ **Yes** ☐ **No**

To assist in walking I use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ No assistance devices used

Do you have any of the following symptoms:

			If yes, explain
General/Constitutional:			
Fever	☐ Yes	☐ No	_____
Chills	☐ Yes	☐ No	_____
Fatigue	☐ Yes	☐ No	_____
Skin/Allergy:			
Rash	☐ Yes	☐ No	_____
Itching	☐ Yes	☐ No	_____
Sweating	☐ Yes	☐ No	_____
Musculoskeletal:			
Joint Stiffness	☐ Yes	☐ No	_____
Joint/Bone Pain	☐ Yes	☐ No	_____
Joint swelling	☐ Yes	☐ No	_____
Muscle cramps/pain	☐ Yes	☐ No	_____
Back Pain	☐ Yes	☐ No	_____
HEENT:			
Headaches	☐ Yes	☐ No	_____
Dizziness/Vertigo	☐ Yes	☐ No	_____
Fainting	☐ Yes	☐ No	_____
Sensitivity to light	☐ Yes	☐ No	_____
Sinus congestion	☐ Yes	☐ No	_____
Nose Bleeds	☐ Yes	☐ No	_____
Facial Pain	☐ Yes	☐ No	_____
Endocrine:			
Jaundice	☐ Yes	☐ No	_____
Neck swelling	☐ Yes	☐ No	_____
Heat/Cold intolerance	☐ Yes	☐ No	_____
Weight loss/gain	☐ Yes	☐ No	_____
Appetite change	☐ Yes	☐ No	_____
Male: Erectile problem	☐ Yes	☐ No	_____
Female: Abdominal bleeding/discharge pain	☐ Yes	☐ No	_____
Respiratory:			
Wheezing	☐ Yes	☐ No	_____
Cough	☐ Yes	☐ No	_____
Shortness of Breath	☐ Yes	☐ No	_____
Cardiovascular:			

Chest Pain	☐ Yes	☐ No	_____
Palpitations	☐ Yes	☐ No	_____
Leg/Feet swelling	☐ Yes	☐ No	_____
Hematological:			
Easy bruising	☐ Yes	☐ No	_____
Easy bleeding	☐ Yes	☐ No	_____
Abnormal clotting	☐ Yes	☐ No	_____
Lymph Nodes:			
Enlargement	☐ Yes	☐ No	_____
Tenderness	☐ Yes	☐ No	_____
Gastrointestinal:			
Difficulty Swallowing	☐ Yes	☐ No	_____
Heartburn	☐ Yes	☐ No	_____
Constipation	☐ Yes	☐ No	_____
Diarrhea	☐ Yes	☐ No	_____
Change in stool	☐ Yes	☐ No	_____
Nausea	☐ Yes	☐ No	_____
Vomiting	☐ Yes	☐ No	_____
Genitourinary:			
Painful urination	☐ Yes	☐ No	_____
Difficult urination	☐ Yes	☐ No	_____
Urgency/frequency	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Blood in urine	☐ Yes	☐ No	_____
Neurological:			
Fainting	☐ Yes	☐ No	_____
Weakness/paralysis	☐ Yes	☐ No	_____
Tremors	☐ Yes	☐ No	_____
Incoordination	☐ Yes	☐ No	_____
Headaches	☐ Yes	☐ No	_____
Migraines	☐ Yes	☐ No	_____
Psychiatric:			
Depression	☐ Yes	☐ No	_____
Suicidal thoughts	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Sleep disturbance	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Memory Loss	☐ Yes	☐ No	_____

X _____

Patient Signature (Print)

Date: _____

CONSENT TO BILL, TREAT, RELEASE INFORMATION

AND FINANICAL RESPONSIBILITY GUARANTEE

Please read carefully before signing

CONSENT TO MEDICAL CARE: By my signature and or electronic signature below, I hereby request and authorize the physician and other health care providers of Chesapeake Pain & Wellness (the Practice), and their professional staff, to perform any medical diagnostic procedures and give medical care, which in their professional judgement is deemed necessary to diagnose and/or treat the conditions that have brought about my seeking medical care services of the Practice. I understand that the practice of medicine is not an exact science, and there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of the Practice.

INSURANCE ASSIGNMENT: If I have insurance with which the Practice participates, a claim for reimbursement for services rendered will be submitted based on the information I provided to Chesapeake Pain & Wellness (Practice). If due to incomplete or incorrect information, payment has not been received by the Practice within 48 days from the date of service, all charges become my responsibility and are immediately payable by me.

FINANCIAL AGREEMENT AND GUARANTEE: I accept full and complete financial responsibility for all charges of the Practice for its provision of medical services, items and supplies to me. I agree to pay any and all copayments, deductibles, and coinsurance amounts at the time of service. Provided the Practice advises me in advance that my health benefit plan does not cover a specific service and I still elect to receive that service, I agree to be solely financially responsible for the payment for the Practice's provision of the 'non-covered' service.

PATIENT RESPONSIBILITY FOR NON-CONTRACTED PLANS: My signature below acknowledges that the Practice has informed me if they are not contracted with my insurance plan that as a courtesy, they will provide me with a form listing the services (procedures) and the reasons for the services (diagnoses) for me to submit for possible reimbursement by my insurance company.

REFERRALS/AUTHORIZATIONS: If required, I understand that without a referral/authorization from my insurance carrier, I am financially responsible for all charges I incur.

HIPPA Regulations: I attest that I am a member, employee or agent of any media or law enforcement agency. It is illegal to film/record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio. This is a direct violation of HIPPA regulations and patient/doctor confidentiality.

Falsified Information: I am aware that I can be discharged from the practice and legal action will be taken if I perjured or misrepresented myself, my condition, my intentions or falsified medical records to the physician. I also hereby authorize Chesapeake Pain & Wellness or it's representative, to discuss my medical condition for verification purposes only.

Photo ID / insurance card: To help combat medical identity fraud with the Federal Trade Commission, patients must provide a valid photo ID and insurance card at every visit. You will be asked to reschedule if you do not have the appropriate documentation.

SELF-PAY: If on the day services are rendered and I: 1) do not have health insurance or am uncertain as to which health insurance I carry, 2) do not want my insurance to be billed, 3) do not comply with the terms of the insurance policy (including but not limited to, failing to supply adequate insurance information or bring authorization/referral forms), I agree to be financially responsible for all charges incurred, will pay in full for services rendered at the time of the visit and will pursue reimbursement from third parties myself.

WORKER'S COMPENSATION: I understand that if my workers compensation insurance carrier or the Worker's Commission denies my claim, and I fail to supply adequate health insurance information, I will be financially responsible for any unpaid balances. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain the referral/authorization even though your Worker's Compensation insurance carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once Worker's Compensation denies the claim. In such situation, I agree that I am financially responsible for the unpaid balance.

MOTOR VEHICLE ACCIDENT/PERSONAL INJURY: We will file claims with your PIP carrier with the necessary documentation from your physician. In the event PIP becomes exhausted, your health insurance will be billed, and you will become responsible for any co-payment or deductible. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain the referral/authorization even though the PIP carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once PIP has been exhausted. In such situations, I agree that I am financially responsible for the unpaid balance.

MISSED APPOINTMENTS: If you fail to provide at least 24 hours' notice to cancel or fail to show up for a scheduled appointment, we have the right to charge a $25.00 missed appointment fee. Chesapeake Pain & Wellness reserves the right to discharge a patient in the event of 3 no-shows or late cancellations. All missed appointment fees must be paid in full before future care is rendered.

RETURNED CHECKS: There will be a returned check fee of $36.00 assessed for any check returned for insufficient funds.

MEDICAL RECORDS: All medical record request must have the patient's signed consent giving permission to Chesapeake Pain & Wellness to release. Please allow 2 weeks for the copying of the medial records. I understand I must pre-pay the copying fee based up allowed charges under current Maryland law for copying medical records. Patient's or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not Worker's Compensation), physician change or relocation from the area are subject to a processing charge in addition to the copying charge. There will be no charge for copying records for a referral to another physician made by a Practice physician, Worker's Compensation issue, or any other solutions covered by Maryland law.

I also hereby authorize the Practice to disclose all or any part of the medical record of protected health information relating to my care to such insurance companies, or third-party payers that require the information for the payment of medical services rendered to me, consistent with Federal HIPPA.

Signature and agreement: THE UNDERSIGNED, CERTIFY THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE POLICIES AND REGULATIONS.

Signature of patient or parent/legal guardian: _____

Date: _____

Relation to patient if parent or legal guardian: _____

Witness: _____

Patient Awareness of New HIPAA Rights

The Maryland Department of Health (MDH) is committed to protecting your health information. In order to provide treatment or to pay for your healthcare, MDH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information may be used for a variety of purposes. MDH is required to follow the privacy practices described in this Notice, although MDH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new notice from any MDH agency. It is also posted on their website at http://www.MDH.maryland.gov.

- Right to inspect and copy protected health information
- Right to amend
- All approve uses and disclosures
- Right to an accounting of disclosures
- Right to have reasonable requests for confidential communication accommodated
- Right to file a written complaint
- Right to receive written notice of information practices

Government sites:
http://aspe.hhs.gov/admnsimp - Department of Health and Human Services http://www.hcfa.gov/security/isecplcy.htm - HCFA Internet Security Policy
http://www.wpc-wdi.com/hipaa - Implementation Guides

Non-govt sites:
http://www.wedi.org
http://www.nchica.org
http://www.hipaadvisory.com/

MHCC site:
http://www.mhcc.state.md.us

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth:_____

The information you may release subject to this signed release form is as follows:

☐Complete Records	☐ History & Physical	☐ Progress Notes
☐ Care Plan	☐ Lab Reports	☐ Radiology Reports
☐ Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐ Hospital Reports	☐ Medication Record	☐ Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____
Address: _____
City, State, Zip Code: _____

The purpose/reason for this release of information is as follows:

_____

Signature:

_____ _____

Patient Name (print) **Signature of Patient or Personal Representative**

Authorization for Release of Information to Family Members

Patient name: _____ DOB: _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. If you wish to have your medical or billing information released to a family member, you must sign this form.
Signing this form will only give information to family members indicated below.

I authorize Chesapeake Pain & Wellness to release my medical and/or billing information to the following individual(s):

1. Relationship to patient: _____
2. Relationship to patient: _____
3. Relationship to patient: _____

I understand I have the right to revoke this authorization at any time and I also have the right to inspect or copy the protected health information to be disclosed.
I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.
You have the right to revoke this consent in writing.

Signature: _____ Date: _____

Urine Drug Screen Policy

Prescription pain medications are potentially addictive and must be taken as prescribed.

The number of deaths in the United States from prescription drug overdoses has doubled in the past 10 years to more than 30,000 per year. Prescription medications are the number one abused drug in our country. At Chesapeake Pain & Wellness, we are committed to ensure our patients have the best quality of life possible, and that includes responsible prescribing; of controlled and non-controlled medications. Part of this responsibility includes drug screenings. Drug screens will be performed at every visit prior to seeing the physician.
Please be prepared to offer a urine sample at every visit. If you are unable to provide a urine sample when requested, we will be unable to prescribe any pain medication(s).

Please understand your health and safety is our number one priority. We are committed to providing you with excellent patient care.

Thank you for your understanding and cooperation,

Chesapeake Pain & Wellness

By signing below, I understand urine drug screens are a part of the medication agreement for Chesapeake Pain & Wellness. I agree to participate in providing a urine sample when requested by Chesapeake Pain & Wellness staff to ensure compliance with my prescribed medication(s).

_____ _____

Patient Name (Print) Patient Signature

_____

Date

Medication Agreement

As a part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed by my doctor.
2. I will never share, sell or exchange my medications with anyone for any reason.
3. I understand I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I understand Chesapeake Pain & Wellness will NOT replace Lost or Stolen prescriptions or controlled medications.
4. I understand I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive functions.
5. I agree to notify Chesapeake Pain & Wellness if I experience adverse effects or dosage problems with my prescribed medications.
6. I agree if I receive a controlled substance prescription from Chesapeake Pain & Wellness, I WILL NOT accept controlled substance prescriptions (any pain medication(s)) from any other physician without my doctor's consent.
7. I agree to use only one pharmacy for my pain-related medications. If circumstances require the use of another pharmacy, I will notify Chesapeake Pain & Wellness of this immediately and provide them with all pertinent contact information.
8. I understand prescriptions involving narcotics require a scheduled visit in the office. Narcotic refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.
9. I agree to keep all scheduled appointments. I understand that no medications will be given for cancelled or no-show appointments. I understand I may not be seen at the office without a scheduled appointment for any reason
10. I understand that I may be asked to bring any or all my prescribed medications to my office appointment randomly for a prescription compliance check (pill count).
11. I understand Chesapeake Pain & Wellness will write and dispense medication prescriptions on a 30-day basis. In order to receive another narcotic medication prescription, I must schedule another office visit within 30 days of the date of my current prescription so my doctor can properly evaluate my progress.
12. I understand abusive behavior or harassment towards any Chesapeake Pain & Wellness staff will not be tolerated. The doctor and/or Practice Administrator will determine what actions are considered harassment, on a case-by-case basis and, if warranted, will dismiss the aggressor from the practice, if determined to be found in violation of this policy.
13. I understand dealing with a forged, falsified or altered prescription will result in immediate dismissal from Chesapeake Pain & Wellness and reported to the local police.
14. I attest that I am a member, employee or agent of any media or law enforcement agency. It is illegal to film/record in this office with a video camera, cell phone or any other recording devise be it a still image, video or audio. This is a direct violation of HIPPA regulations and patient/doctor confidentiality.
15. I am aware that I can be discharged from the practice and legal action will be taken if I perjured or misrepresented myself, my condition, my intentions or falsified medical records to the physician. I also hereby authorize Chesapeake Pain & Wellness or it's representative, to discuss my medical condition for verification purposes only.
16. I understand Chesapeake Pain & Wellness reserves the right to perform a urine drug screen at any time while I am being treated with prescribed controlled substances. If the results of the urine drug screen do not reflect prescribed medication by my physician, or if illegal drugs are present in my sample, I understand I will be dismissed immediately from the practice.
17. I understand if I have a problem, or need to change my medication(s), I will make an appointment, and bring in all medications currently prescribed by my doctor to that appointment. If I fail to bring them, the doctor will not issue a new prescription.

By signing this agreement, you are affirming your full right and power to be bound by this agreement. You are affirming you have read, understand and accept these terms. Non-compliance with this agreement will be terms for dismissal from Chesapeake Pain & Wellness.

_____ _____

Patient Name (Printed) **Date**

_____ _____

Patient Signature

_____

_____

Pharmacy Name/Phone Number/Address