PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the "Notice of Privacy Practices", and I have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____

Date: _____

CONSENT FOR USE OF PROTECTED HEALTH INFORMAITON

With my consent, Georgia Pain and Wellness may call the following contacts at the phone numbers listed below, to verify appointments for myself,

_____:
(Patient's Name)

_____ _____
(Contact) (Phone Number)

The following are people with whom Georgia Pain and Wellness, LLC may share my medical information, including medications being prescribed, treatment plans and/or appointment dates:

_____ _____
(Contact) (Phone Number)

_____ _____
(Patient's Signature) (Date)

_____ _____
(Witness) (Date)

CANCELLATION AND NO SHOW POLICY

Our goal is to meet the needs of all our patients, we will make every effort to schedule your appointment as efficiently as possible. In return, ***it is your responsibility to make every effort to keep your appointment and to arrive promptly at the time instructed.*** However, we realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least ***24 hours before your scheduled appointment*** to avoid paying a fee of $25.00. This fee is not covered by your medical insurance or worker's compensation benefits.

The cancellation / rescheduled fee must be paid on or before your next schedule appointment.

Thank you for your attention in this matter.

By signing below, I acknowledge that I have read and understand the cancellation and no show policy and agree to abide by these guidelines.

_____ _____

Patient Signature Date

FINANCIAL POLICY

Insurance coverage is a contract between you, the patient, and your insurance company; therefore, any questions about policy coverage or claims payment should be directed to your carrier. Your insurance carrier will determine the insurance reimbursement. You will receive a statement each month if your account has a balance due.

While the filing of the insurance is a courtesy that we do extend to our patients, all charges are the patient's responsibility from the day the services are rendered. We realize that temporary financial problems may, at times, affect timely payment of your account. Upon request, special considerations may be extended. To avoid any misunderstanding, we ask that you make these arrangements with the financial counselor prior to services being rendered.

I understand from time to time I may incur services that my insurance company considers to be not medically necessary and/or non-covered. I agree and warrant that in such an event, I will pay for those charges incurred about this determination. I have read, understand and agree to the financial policy as stated above.

_____ _____

Patient's Signature Date

_____ _____

Witness Date

Patient Medication Management and Treatment Agreement

This agreement between _____ (Patient) and Georgia Pain and Wellness (The Center) is for the purpose of establishing the conditions required for the use of Opiate / Prescription medications that the Physician may prescribe for the patient. The Center and the Patient agree that this agreement is an essential factor in maintaining a proper and appropriate medical relationship and for the proper and appropriate medical relationship and for the proper and appropriate implementation of medical treatment pursuant to the guideline of the DEA, and all other local, state and federal regulatory rules and regulations.

The Patient agrees the following conditions for the management of pain medications prescribed by the physician for the patient. Please **initial** by each one.

☐ 1. Patient understands that a reduction in the intensity of pain and an improvement in their quality of life are the goals of this center.

☐ 2. Patient realizes that all medications have potential side effects. In addition to analgesia, prescriptions prescribed by the physician may produce dependency, addiction, respiratory depression, drowsiness, mood changes, anxiety, and mental impairment.

☐ 3. Patient agrees to report any of the above described side effects immediately to their treating physician at the center.

☐ 4. In the event, any prescribed medications need to be discontinued by the physician, patient agrees to consult with physician and strictly follow physicians care instruction for the safe adjustment of any prescribed medications. Failure by the patient to do so may result in severe withdrawal effects and possible death. Patient understands that even with the prescribed lowering of doses the patient may suffer and experience discomfort and withdrawal symptoms, said symptoms should be immediately reported to the center and the physician.

☐ 5. Patient understands the risks, side effects and benefits of any applicable prescribed medications and patient acknowledges that the center and physician have fully explained and discussed all risks, side effects and benefits of any applicable prescribed medications in detail.

6. The center and physician have discussed and explained to me in detail that medications prescribed to me may impair my mental, and or physical abilities required for the performance of certain tasks and activities such as driving an automobile or preforming hazardous tasks.

☐ 7. Patient agrees that the patient will not attempt to perform any such activity until patient ability to perform such tasks has been evaluated by the center or physician.

☐ 8. Patient has been advised and informed by the center and physician that patient should not take any other drugs, prescription medications, sedative, tranquillizers, antihistamines, alcohol, or other "over the counter medications" without first consulting with physician. The center and physician have explained to the patient that taking any of the above in conjunction with any medications prescribed by the physician may produce dangerously profound effects including, but not limited to sedation, respiratory dysfunction, blood pressure changes and depression.

☐ 9. Patient agrees that he / she will not attempt to obtain prescriptions for any pain medications from other physicians and or pain management facilities. Patient understands that it is a violation of both Georgia and Federal Laws to do so and will result in felony charges.

☐ 10. Patient has been advised that in the event the center and or physician becomes aware of the patient attempting to or receiving pain medications from other physician or facility that the patient will be brought in for their follow up and pay for their visit and then discuss with the physician being discharged from the practice and could face felony charges. This cannot be done over the phone.

☐ 11. Patient declares to the center and physician that the patient is not presently using any illegal drugs, alcohol, or controlled substances (other than medications prescribed by the clinic) while in the care of the center and its physician.

☐ 12. Patient consents and agrees to allow the center and physician to pill counts, blood testing and urine testing while a patient at the center.

☐ 13. Patient agrees that patient shall not under any circumstances sell, share, trade or market any medications prescribed by physician to any other individual or entity regardless of the circumstances as said conduct is illegal and punishable by law.

☐ 14. Patient agrees not to conspire with any other individual or entity in order to obtain any prescription pain medication from any pharmacy other than the specific pain medication prescribed by the physician at the center.

☐ 15. Patient agrees to use due care in protecting their prescription from loss or theft. Patient has been advised and agrees that all prescriptions prescribed by physician shall be kept out of the reach of children.

☐ 16. Patient acknowledges that patient is responsible for taking any prescribed medication(s) prescribed by physician, in the exact and specific dose prescribed by the physician at the center.

☐ 17. All follow up visits to the center will be scheduled no earlier than 28 days, and not later than 30 days. Patient understands that the visits and follow up treatment is required for the proper management and treatment of the patients including, but not limited to prescription medications prescribed by the physician. Re-fills on prescription medications will not be called in by the physician or the center and will only be re-filled pursuant to the patients follow up schedule and medical necessity.

☐ 18. All female patients should immediately notify physician if they are pregnant, at risk of becoming pregnant or may be pregnant. Failure to do so may cause harm or injury to the unborn child.

☐ 19. Patient agrees that in the event of an investigation by any Local, State or Federal Agency (including Georgia State Board of Pharmacy), Patient authorizes center and physician to cooperate, and patient waives any and all applicable HIPPA Privacy Rules and Regulations relating to the patient confidentiality and herby authorizes center and physician to disclose patients medical information.

☐ 20. In the event that the center or physician determines that patient may be doing harm to themselves or others by either abusing prescribed medication, selling prescribed medication or "doctor shopping" this document will serve as a release of medical information in compliance with HIPPA regulations for the center or the physician to obtain any records from any center or physician regarding any prescribed pain medication and treatment records.

☐ 21. If patient has either been on probation in any state, or if the patient has ever been arrested or charged with any narcotic or drug related offense, patient understands that the patient must disclose this information to the center and the physician.

☐ 22. In the event patient changes pharmacies, patient agrees to immediately notify center and physician of such change.

☐ 23. Patient understands and agrees that center an or physician reserves the right to perform a urine drug test at any time while patient is being treated and or receiving prescribe medication from physician. In the even the test results determine to be positive for any other substance other than that that is being prescribed by the physician, or any substance that is not documented in the patients chart as being prescribed by another treating physician, the patient understands that they can be dismissed immediately and all prescription medication will be cancelled immediately and the patient will be referred to an addictionologist for clearance before any other treatment will be considered.

☐ 24. Patient agrees that any suspicions misuse of prescribed medication by either the center or the physician may result in immediate discharge of the patient and termination of any prescribed medication and treatment plan. Patient also understands that they will be referred to an addictionologist for clearance before any future treatment will be considered.

☐ 25. Patient understands that at any time during treatment should the physician or center suspect that the patient is falsifying symptoms and or any documents in order to either be treated or obtain medications; physician shall immediately discharge the patient.

☐ 26. I understand that the physical dependence is not the same as addiction. I am aware of the physical dependence means that if my pain medicine use is markedly decrease, stopped, or reversed I will experience withdrawal symptoms. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, adnominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, and could even result in heart attack, stroke, or death.

☐ 27. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form or treatment, reduce the dose, or stop it.

By signing this agreement, patient agrees to abide by the terms of this agreement, and patient agrees that the failure to abide by the terms of this agreement may result in immediate termination of treatment and prescription medication.

Patient Signature	Date
Witness Signature	Date
Physician Signature	Date