dallaspainconsultants

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____

Patient's Full Name: _____**Birth Date:** _____

Sex: ☐ **M** ☐ **F** **Marital Status** ☐ **S** ☐ **M** ☐ **D** ☐ **W** **Ethnicity** ☐ **Hispanic** ☐ **Latino** ☐ **Not Hispanic or Latino**

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Social Security:_____

Please list two confidential numbers we are able to leave messages to:

Cell Phone No: (_____)_____ **Other Phone No:** (_____)_____

E- Mail: _____

Referring Physician:_____**Phone #:**_____

Primary Care Physician: _____**Phone #:**_____

Cardiologist :_____**Phone #:**_____

Pharmacy:_____**Phone #:**_____

Work Status: Retired / Unemployed / Student / Full Time / Part Time: **Patient Occupation:** _____

Patient Employer: _____ **Employer Phone No.** (_____)_____

Name of Primary Insurance: _____

Patient's Relationship to Subscriber: **Self** **Spouse** **Child** **Other** _____

Policy # _____**Group #** _____

Subscriber's Name: _____ **Subscriber's S.S. #** _____ **Birth Date** ___/___ /_____

Name of Secondary Insurance (if applicable): _____

Patient's Relationship to Subscriber **Self** **Spouse** **Child** **Other** _____

Policy # _____**Group #** _____

Subscriber's Name: _____ **Subscriber's S.S. #** _____ **Birth Date** ___/___ /_____

Is this a Workers' Compensation Injury? Yes No If Yes – Please see the front desk

Emergency Contact: : _____

Relationship to Patient: _____ **Contact Phone No.**(_____) _____

____ the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dallas Pain Consultants or insurance company to release any information required to process my claims.
____ Dallas Pain Consultants provides the opportunity for patients to communicate by email. By providing an electronic mail address to Dallas Pain Consultants, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Dallas Pain Consultants cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Dallas Pain Consultants intentional misconduct.

_____

PATIENT/GUARDIAN SIGNATURE DATE

New Patient Health History and Pain Management Questionnaire

Date: _____ Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Male / Female

Referring Physician: _____ Primary Care Physician (Required):_____

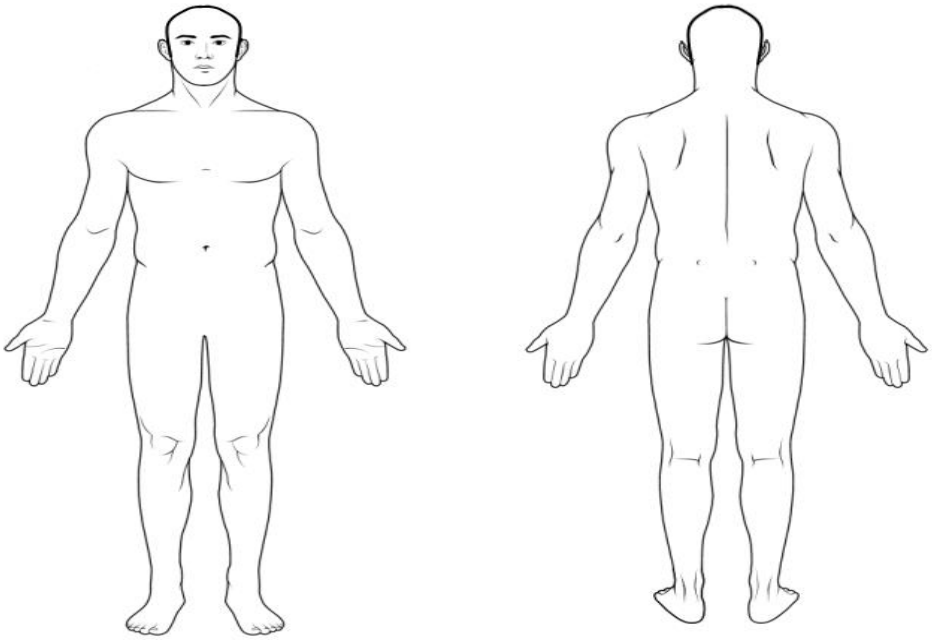
Pharmacy Preference: _____ Phone #: _____

Date of first episode of pain: _____ **Date of Diagnosis**: _____

Under what circumstances did the pain begin?

☐ Work Accident ☐ Home Accident ☐ Auto Accident ☐ Surgery ☐ Fall ☐ Other _____

PLEASE INDICATE WHERE YOUR PAIN IS BY MARKING THE DIAGRAM BELOW



PLEASE INDICATE YOUR PAIN BY CIRCLING:

YOUR PAIN AT THE PRESENT TIME: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AT ITS WORST: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AT ITS LEAST: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AS IT USUALLY IS: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

SINCE YOUR PAIN BEGAN IT HAS: INCREASED DECREASED STAYED THE SAME

Describe your pain briefly (include location of your pain):

_____

☐ Aching ☐ Throbbing ☐ Stabbing ☐ Shooting ☐ Burning ☐ Penetrating ☐ Sharp

Print Name/Date of Birth _____

Do you have any of the following?
☐ Numbness ☐ Tingling (Pins & Needles) ☐ Weakness ☐ Coldness ☐ Muscle Spasm ☐ Tightness

Is it: ☐ Constant ☐ Off and on

Are you able to control: Urination: ☐ Yes ☐ No **Bowel Movements:** ☐ Yes ☐ No

Does pain interfere with your sleep? ☐ Never(0 times/month) ☐ Seldom (4 times/month)
☐ Occasional (5 time/month) ☐ Often (10 times/month ☐ All the time (every night)

What makes the pain worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Coughing ☐ Bending over ☐ Exercise
☐ Lifting ☐ Deep Breathing ☐ Lying on your back Other_____

What makes the pain better?
_____

Do you take pain medication? ☐ YES ☐ NO **If yes, describe the effect:**_____

How long does the pain relief last? _____

How many times a day do you take pain medication? _____

In the past 2 weeks, have you taken more, the same or less pain medication? _____

Has the pain caused depression or other emotional problems? ☐ YES ☐ NO **If yes, have you sought medical care?**
_____

Has the pain affected your ability to work? ☐ YES ☐ NO **For how long?** _____

Has the pain affected your ability to enjoy life, personal relationships, other? ☐ YES ☐ NO

What are your treatment goals? ☐ Pain reduction ☐ Decrease medication intake ☐ Avoid surgery
☐ Increase daily activities ☐ Return to work ☐ Improvement of quality of life

What diagnostic test(s) or treatment(s) have you had? Please indicate when and where they were done.

	Date	Location
X-ray		
MRI/CT Scan		
EMG		
Epidural Steroid Injection		
	Date	Location
Physical Therapy		
Chiropractor/Acupuncture		

Print Name/Date of Birth _____		
Braces/TENS unit		
Psychologist		
Comprehensive Pain Clinic		
Other_____		

List medications to which you are allergic:

Medication **Type of Reaction** (rash, itching, swelling, etc.)

_____ _____

_____ _____

_____ _____

Do you have an allergy to latex? ☐ Yes ☐ No Reaction_____
Do you have an allergy to iodine? ☐ Yes ☐ No Reaction_____

Are you currently taking anti-coagulants or blood thinners? ☐ Yes ☐ No **(Please check all that apply)**

☐ **Coumadin** ☐ **Aspirin** ☐ **Plavix** ☐ **Anti-inflammatories or any others?**

Who is prescribing this for you? Doctor:_____ Tel #:_____

List of medications (including over the counter) **Dosage** **Number of Times you take a day**

_____

_____

_____

Past Surgeries and Hospitalizations – List ALL surgeries and hospitalizations with date:

_____

_____

_____

Past Medical History – List ALL current and past medical conditions (i.e. high blood pressure, diabetes, COPD,etc.)

_____

_____

Print Name/Date of Birth _____

Past Family History – List all medical conditions a family member has, had or died from:

_____

_____

Social History:

Work Status: ☐ Employed ☐ FT ☐ PT ☐ Retired ☐ Disability ☐ Permanent ☐ Temporary

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____ Month? _____

Tobacco use? ☐ Yes ☐ No **Number per day of:** Cigarettes ____Cigars_____ Chewing tobacco _____E-cig____

What year did you start? _____ What year did you quit? _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, what type and when was your last use?

_____

Have you ever been treated for alcohol dependence or addiction? ☐ Yes ☐ No

Have you ever been treated for drug dependence or addiction? ☐ Yes ☐ No

Systems Review: Check any of the following which you have had in the **last 3 months or currently** have:

General: ☐ Fatigue ☐ Fever or chills_____ **Nutritional**: ☐ Unexplained weight loss
Skin: ☐ Psoriasis ☐ Eczema ☐ Rash/hives_____
Respiratory: ☐ Asthma/wheezing ☐ Bronchitis ☐ Chronic cough ☐Shortness of Breath ☐ COPD ☐ Sleep Apnea_____
Cardiac: ☐ Chest pain ☐ High blood pressure ☐ Irregular pulse ☐ Swollen ankles ☐ Varicose veins ☐ Pacemaker
Gastrointestinal: ☐ Chronic abdominal pain ☐ Bloody or tarry stools ☐ Colitis ☐ Constipation ☐ Heartburn ☐ Hepatitis ☐ Nausea/vomiting ☐ Loss of control of stool ☐ Urinary: Blood in urine ☐ Frequent urination ☐ Kidney stones ☐ Kidney failure ☐ Loss of urinary control
Musculoskeletal: ☐ Aching joints ☐ Back pain ☐ Bone fracture ☐ Neck pain ☐ Muscle spasms or tightness ☐ Weakness
Neurologic: ☐ Dizziness ☐ Passing out ☐ Headache ☐ Muscle weakness ☐ Numbness/tingling ☐ Seizures ☐ Tremor ☐ Loss of control of arms or legs
Endocrine: ☐ Frequent thirst ☐ Frequent urination ☐ Cold or heat intolerance
Psychiatric: ☐ Depression ☐ Bi-polar disorder ☐ ADHD/ADD ☐ Memory Loss ☐ Anxiety ☐ Sleeping difficulty

Consent for Use & Disclosure of Protected Health Information

Patient Name:_____

Date of Birth:_____ Social Security #:_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment.

I understand that this information servies as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the right to:

- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- Revoke this consent in writing, except to the extent that the organization has already taken the action in reliance therein.

I have received a copy of Dallas Pain Consultants' Noticy of Privacy Practices.

_____ _____

Patient Signature Witness

_____ _____

Date Date

Financial Policy

Thank you for choosing Dallas Pain Consultants for your pain management needs. Our financial policy outlines our practice guidelines which should allow you to receive all the benefits offered to you by your health plan. We ask that you read and follow these guidelines, which are necessary to facilitate your care.

Insurance: Insurance cards should be available upon request at all visits. If you have a change of address, telephone number, employer, insurance plan or coverage, please notify the receptionist. We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies and the member. Any dispute for unpaid charges from the insurance company will be billed to the member.
Further Information:

- **HMO plans or other managed care policies -** You are responsible for obtaining any referral required by your insurance. If a referral is not on file prior to your visit, your appointment will be canceled or rescheduled until one is obtained. Depending on the particular plan, please verify the number of visits permitted. You will be responsible for any visits not authorized.
- **Contract –** Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. It is important that you understand the provisions of your policy, as we cannot guarantee payment of claims.

Copays/Coinsurance & Deductible – All copays, coinsurance & deductibles are due at the time of service.

Procedures & Injections Costs – In all cases we collect an **estimate** of your financial responsibility amount at the time of service. If you are scheduled at an outpatient facility we will collect the **estimated** amount prior to your appointment. Procedures & injections may be rescheduled if the estimated amount is not paid on or prior to the time of service. This will be an estimate ONLY and may be subject to change depending on the services provided. We will either bill you for the remaining balance or credit any overpayment in a timely manner. Payment plans are available upon request, please contact us PRIOR to your appointment. Unless you make prior arrangements our financial policy will stand.

Charges for Forms - Our charge for completing FMLA, Disability or Life Insurance paperwork is $35.00 per form and is due in full before the paperwork can be picked up, faxed or mailed. Allow 7-10 days processing.

No Show Fees - We require 24-hour notice for appointment cancellations. In the event you do not give the required notification a no-show fee will be assessed. Office visits will incur a $25.00 fee and procedures/injections will incur a $100.00 fee. Patients who habitually fail to keep appointments may be discharged from our clinic.

Returned Checks - A $25.00 fee will be charged for any returned checks and we will no longer accept your checks.

Payment Methods – We accept cash, checks (Under $100), money orders and all major credit cards (VISA, Mastercard, Discover & American Express)

Account Billing Questions & Refunds – Questions or concerns regarding your account or insurance claim can be directed to our billing department (214) 948-7700 Ext 201. If your account has a credit balance we will issue a refund once all outstanding claims on your account have processed.

My signature below represents that I have read and have a full understanding of Dallas Pain Consultants Financial policy. I may also request a copy of the signed policy for my own records.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Assignment of Benefits

1. Assignment of Benefits:
   Please remember that insurance is considered a method of reimbursing that patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage for the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

   IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID PRIOR TO EACH VISIT.

   I understand that I am responsible for providing Dallas Pain Consultants all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

   I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Dallas Pain Consultants. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignees to release all information necessary to secure payment.

2. Medicare / Medicaid Assignment of Benefits: (Does not apply if you DO NOT have Medicare or Medicaid)
   a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or tis intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

      Initial _____

   b. I understand that Medicaid recipients are responsible for payment of any medical care for service received that is beyond the amount, duration and /or scope of the Texas Medicaid Program, as determined by the Medicaid Department or tis health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

      Initial _____

_____ _____

Print Patient Name Date

_____ [ ] Patient under 18 years of age

Patient Signature

_____

Witness

dpc
dallaspainconsultants

Nurse Practitioner and Physician Assistant Consent

Here at, Dallas Pain Consultants, we strive to offer you high quality medical care and give strong consideration to your wait time. We employ Advanced Practice Registered Nurses, also known as Nurse Practitioners and/or Physician Assistants to assist us in carrying out your plan of care.

Nurse Practitioners and Physician Assistants have received advanced education and training in the provision of health care. They are graduates of a certified training program and licensed by the Texas State Medical Board. They can diagnose, treat and monitor routine and complex pain disorders as well as provide health maintenance care. If you are seen by one of these providers, your doctor will review your care with them as part of your treatment plan. "Supervision" does not require the constant physical presence of the supervising physician, but rather, observing the activities of accepting responsibility for the medical services provided.

I have read the above and understand that in this practice a team approach is used with my unique needs presented and reviewed by one or more physicians in the development of my plan of care. I also understand that from time to time I may be seen by any or all of the providers in this practice, including the physicians, Nurse Practitioners and Physician Assistant.

I hereby consent to the services of a Nurse Practitioner or Physician Assistant for my healthcare needs.

I understand that I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician. I understand that this may require my appointment to be rescheduled.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

dpc
dallaspainconsultants

Disclosure of Physician Interest

To better serve you, our physicians, Trevor Kraus MD and Darren Schuhmacher MD have ownership or financial interests in various other health care providers and/or facilities. Our physicians are committed to providing high quality health care services to our patients and may refer you to one of these providers and/or facilities to receive health care items or services that he has determined you need. Their ownership interest in these often provides them a voice in administrative, clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service.

Please note that, as of the date of this notice, Dr. Kraus/Schuhmacher have ownership or financial interest with the following providers / facilities / services:

SurgCenter of Plano Ambulatory Surgery Center
Principle Health Systems
Southern Diagnostic Monitoring
Pharmacy Services
Texas Anesthesia Solutions

- During the course of our physician/patient relationship I may refer you to a provider/facility or service.
- I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care provider/facility/service other than the provider/facility/service to which I might refer you.
- I will not be treating you differently if you choose to obtain health care from a provider/facility/service other than the provider/facility/service in which I have an ownership or financial interest. If you desire I will be happy to provide information about alternative providers/facilities/services.

If you have questions please do not hesitate to ask. We welcome you as a patient, and we value our relationship with you.

By signing below you acknowledge that you have read and understood this Disclosure, and that you are aware of the Physician ownership or financial interest.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Authorization to Release Information

In order to protect your privacy under HIPAA, we have created this consent form for releasing medical information about you, for treatment, payment, and health care operations, or to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the mentioned phone numbers. Many times we have patient's family member's call requesting medical information and legally we are not allowed to release that information without the patient's written consent. The purpose of this document is to protect your privacy.

I, _____, authorize Dallas Pain Consultants (DPC) to furnish requested information
Print Patient Name
from the patient's medical and other records to: (1) any insurance company or third party for purpose of obtaining payment on account of DPC, (2) the disability insurance company to expedite my claim, (3) any other person(s) or entities financially responsible for the patient's care or treatment, and (4) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable disease such as Acquired Immune Deficiency Syndrome ("AIDS"). I also authorize the release of information and /or review of patient's records for purpose of conducting medical audits, utilization reviews, or quality assurance reviews.

I hereby give my permission for the release of medical information regarding appointment and questions about my condition and treatments to the following person(s):

Name:
_____Relation:_____Phone:_____

Name:
_____Relation:_____Phone:_____

Name:
_____Relation:_____Phone:_____

Do you have an Advance Directive? Living Will? (Please circle) Yes or No

Consent and Agreement: I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information.

_____ _____
Patient Signature Date

Notice of Urine Drug Screening Policy

- Dallas Pain Consultants will screen patients through urine testing to confirm & monitor medications. With this and your other diagnostic information, we can prevent harmful drug-to-drug interactions and identify ways to refine your treatment plan, if necessary.
- Patients may be screened at their initial visit and subject to randomized testing while under our care.
- Our request for a urine sample does not mean that we suspect anything or that you may be doing anything wrong.
- We reserve the right to withhold additional prescriptions if a patient refuses to submit to urine screening.
- Positive drug screens could result in withholding of additional prescriptions and/or separation of care.
- Through regular, routine monitoring, we feel that we are showing you our commitment to helping you manage your chronic pain and protecting your safety. The information from your test results will help us to determine if you are taking the medication correctly and if your treatment plan is progressing as planned.

We appreciate your cooperation with testing.

Print Patient Name Date of Birth

Patient Signature Date

Pain Management Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to ensure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Controlled substances can be considered for moderate-to-severe pain with the intent of reducing pain and increasing function. The goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship as well as full understanding of the risks and benefits of using controlled substances to help manage your pain. The following are policies our office follows in managing the administration of these medications.

- Pain medication prescriptions are obtained only from our office. If prescription for pain medication are obtained from other physicians this may result in termination of the physician-patient relationship.
- The following exception applies:
    - If you have a dental procedure or are seen in the emergency room, that physician may prescribe pain medicine as they deem necessary.
    - If you have surgery, the surgeon will be responsible for prescribing your pain medications until your discharge from their care.
- Fill prescriptions for pain medications at one pharmacy. Should the need arise to change pharmacies, notify our office.
- Inform your physician of all medications you're taking, including herbal remedies, over the counter medications, and other prescribed medication since controlled substances can interact with these.
- You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
- Prescribed medications must be taken strictly as ordered. Failure to do so may result in termination of physician-patient relationship and/or termination of prescription privileges.
    - If your pain worsens or if there's a change in your symptoms, do not take more medication that is prescribed. Please make an appointment to be seen in the office.
- Refills of controlled substances will be given to the patient during regular office visit scheduled appointment. Refills will not be made at night, on weekends, or during holidays. Please come to each office visit with the actual prescription bottles of the medications you are currently taking so that the review of current medications can be done at such visit.
- You're responsible for keeping your pain medication in a safe and secure place. Stolen medication should be reported to the police and your physician immediately.
- Lost, misplaced, stolen medication or their prescriptions will not be refilled early. You are responsible for taking medications as prescribed and for keeping track of the amount of medications remaining.
- It is against the law to give or sell your medications to any other person.

- If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since a treatment with controlled substances for pain increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for treatment of pain with controlled substances, but starting or continuing a recovery program is required.
- You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician deems it necessary.
- **You agree and understand that your physician reserves the right to perform random or unannounced urine drug screening**. If requested to provide a urine sample you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including the discontinuation of your controlled substances or complete termination of the doctor-patient relationship.
- You should not use any illicit substances, such as cocaine, marijuana, etc. The presence of non-prescribed drug(s) and/or illicit drug(s) in the urine may result in change in your treatment plan, such as the safe discontinuation of your prescribed medications and/or termination of the doctor-patient relationship. Urine drug testing is done for your benefit as a tool to monitor patient compliance and in accordance with the standard of care of the Texas Board of Medical Examiners requirements on the use of controlled substance to treat pain. You accept responsibility for the cost of the urine test in the event your healthcare coverage will not cover the cost of this test.
- Any evidence of drug hoarding, acquisition of any controlled substances from other physicians (exceptions as noted above), uncontrolled dose escalation or reduction, loss of prescriptions, any deviation from your treatment plan, or failure to follow this agreement, may result in termination of the doctor-patient relationship.
- You may be referred to an addiction specialist if your doctor deems it necessary.

I understand that if I violate any of the above conditions, my prescription of controlled substances may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual or provider and/or the use of non-prescribed illicit drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.

I have read this agreement and it has been explained to me by the DPC staff. In addition, I fully understand that the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from Dallas Pain Consultants.

_____

Print Patient Name Date of Birth

_____

Patient Signature Date

WARNING REGARDING PHYSICAL DEPENDENCE OF CONTROLLED SUBSTANCES

Physical dependence and/or tolerance can occur with the use of controlled substances.

Physical dependence means that if the controlled substance is abruptly stopped or not taken as directed, a withdrawal syndrome could include, but is not limited to, seating, nervousness, abdominal cramps, diarrhea, goose bumps and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on steroids to treat asthma but not addicted to the insulin or prednisone.

Addictions is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and cravings. This means the drug decreases ones quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of controlled substance may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

It may be deemed necessary by your doctor that you see and addiction medicine specialist at any time while receiving controlled substance medications. Understand that if you do not attend such an appointment your medication maybe discontinued or may not be refilled beyond a tapering dose to completion. If the specialist feels that you are at risk for addiction or psychological dependence, medications will no longer be refilled.

By signing below you are stating that you understand and acknowledge the above.

_____

Print Patient Name Date of Birth

_____

Patient Signature Date

Vault Introduction Letter to Patients – PATIENT COPY

Dear Patients,

Vault is a HIPAA-compliant, cloud-based tool that we've begun using to administer medical assessments and screenings necessary as part of our patients' course of care. We have carefully evaluated Vault and believe it will improve your experience by:

- Allowing you to communicate important health information to your provider efficiently and privately.
- Reducing the time you spend sharing health concerns to medical support staff and providers in the exam room, allowing you to focus on your questions and treatment options.
- Enabling you and your provider to monitor some conditions in between appointments, and adjust the timing and number of follow-ups needed to best address your health needs.

Approximately 48 hours before future appointments for follow ups or medication refills:

- You will be sent an email notification from Vault Support (support@vaultintohealth.com) to take your assessment before you arrive for your appointment. You can take Vault tests on any web-enabled device (computer, smart phone, tablet, etc.) by logging into the Vault website below. If you do not have access to the internet or do not have an email you can complete the questionnaire in office.

Please let any team member know if you have any questions. We appreciate the opportunity to meet your healthcare needs!

My Vault log in information:

Website: http://app.vaultintohealth.com

Email: _____

Password: _____

www.vaultintohealth.com
Support@vaultintohealth.com
(866) 415-1518

Vault Introduction Letter to Patients – CLINIC COPY

Dear Patients,

Vault is a HIPAA-compliant, cloud-based tool that we've begun using to administer medical assessments and screenings necessary as part of our patients' course of care. We have carefully evaluated Vault and believe it will improve your experience by:

- Allowing you to communicate important health information to your provider efficiently and privately.
- Reducing the time you spend sharing health concerns to medical support staff and providers in the exam room, allowing you to focus on your questions and treatment options.
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Please let any team member know if you have any questions. We appreciate the opportunity to meet your healthcare needs!

Name: _____

Signature: _____

Date: _____