CONTACT INFORMATION

_____ _____ _____
Last Name First Name Middle

Date of Birth: _____ Age: _____ Sex: _____

Home Address: _____

_____

Cell Phone: ( ) _____ Smart Phone: YES NO

Landline Home Phone: ( )

E- Mail: _____

WORK INFORMATION

Occupation: _____

Company Name: _____

Work Address: _____

_____

Work Phone: ( )_____

Not Working:

Applying for Disability:

Employer covered health Insurance:

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Occupation: _____

Address: _____

_____

Cell Phone: ( ) _____ Smart Phone: YES NO

PRIMARY INSURANCE

Name: _____

Policy # _____ Group #: _____

Billing Address: _____

Phone: _____ Fax: _____

Type: PPO HMO UNKNOWN

Co-pay (Amount): _____ Individual Deductible ($): _____ Family Deductible ($): _____

Deductible Met: YES NO

If deductible not met can you afford to pay the charges at time of the visit? YES NO

SEND STATEMENTS (Can pay on time) NEED A PAYMENT PLAN

Co-Insurance: PERCENTAGE: _____

For your Co-insurance percentage can you afford to pay the charges time of the visit?

YES NO SEND STATEMENTS (Can pay on time) NEED A PAYMENT PLAN

Need Authorization to see the specialist: YES NO UNKNOWN

Need Authorization to get tests (example: MRI): YES NO UNKNOWN

Need Authorization to get treatments (example: Therapy): YES NO UNKNOWN

Need Authorization to get procedures (example: Epidural): YES NO UNKNOWN

Willing to help in getting the authorizations: YES NO NO TIME

SECONDARY INSURANCE

Name: _____

Policy # _____ Group #: _____

Billing Address: _____

Phone: _____ Fax: _____

Type: PPO HMO HAS UNKNOWN

Co-pay (Amount): _____ Individual Deductible ($): _____ Family Deductible ($): _____

Deductible Met: YES NO

If deductible has not been met can you afford to pay the charges time of the visit?

YES NO SEND STATEMENTS (Can pay on time) NEED A PAYMENT PLAN

AUTO ACCIDENT INFORMATION

Date of Accident: _____

Place of Accident: _____ State: _____

Police Notified? Yes / No Insurance Co. notified? Yes / No

Claim Number: _____

Insurance co: _____

Insurance Policy #: _____

Billing Address: _____

_____

Adjuster's Name: _____

Phone: ( ) Fax: ( )

LAWYER INFORMATION

Lawyer Notified? Yes / No

Are you in Litigation: Yes _____ No _____

Reason for Litigation: _____

_____

Lawyer's Name: _____

Para Legal' s Name: _____

Address: _____

_____

Phone: ( )_____ Fax: ( ) _____

Do you want your medical records released to your lawyer?

Yes _____ No _____

WORKER'S COMP. INFORMATION

Date of injury: _____

Claim Number: _____

Claim Open? Yes / No

Insurance co: _____

Billing Address: _____

_____

Phone: ( )_____ Fax: ( ) _____

Adjuster's Name: _____

Employer's Name: _____

Employer's Address: _____

Phone: ( ) Fax: ( )

LAWYER INFORMATION

Lawyer Notified? Yes / No

Are you in Litigation: Yes _____ No _____

Reason for Litigation: _____

_____

Lawyer's Name: _____

Para Legal' s Name: _____

Address: _____

Phone: ( )_____ Fax: ( ) _____

Do you want your medical records released to your lawyer?

Yes _____ No _____

REFERRING PHYSICIAN INFORMATION

Referring Physician: _____

Address: _____

Phone: ( )_____ Fax: ( ) _____

PRIMARY CARE PHYSICIAN INFORMATION

PCP's Name: _____

Address: _____

Phone: ( ) Fax: ( )

OTHER PHYSICIAN (SURGEON) WHOM YOU ARE REQUESTING CONSULT REPORT

Name of the Physician: _____

Address: _____

Phone: ( )_____ Fax: ( ) _____

PHARMACY INFORMATION

Name: _____

Address: _____

Phone: _____Fax: _____

HIPPA-AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY

Consent: I authorize my physician, physician associates and assistants to provide the medical care, tests, procedure(s) and services considered medically necessary to treat my condition(s). I understand that I am financially responsible to my physician for charges not covered by my insurance and this authorization. I authorize the physician to provide copies of my medical records to referring physician(s)/primary care physician(s)/hospital(s)/health care facilities(s)/lawyers/law enforcement authorities when requested. I also authorize my physician to allow managed care organization to access my medical information for quality review purposes.

Storage and Release of Information: I consent to the electronic storage and transmission of patient health information. I hereby authorize physician practice to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following: •Any governmental or other entity as required by law for the purposes of reporting or purposes of determining eligibility in government sponsored benefit programs. •The listed insurer(s) and/or agents of these companies. •Any referring provider, continuing care, residential or long-term care facility or home health agency, hospital or surgery center where a procedure has been scheduled for the purpose of providing services for my care.

Medicare Insurance Benefits: I authorize the release of medical or other information to the Medicare Program or its intermediaries or carriers concerning this or a related Medicare claim filed by my treating provider(s). I request that payment of authorized benefits be made on my behalf to my healthcare providers. I understand that I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered charges. I request payment of authorized Medigap benefits be made to this provider and also authorize the release to the named Medigap insurer any information needed to determine benefits payable to the provider. Medicare will only pay for services it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. In that case, I agree to be responsible for payment.

Guarantee of Payment: In accordance with the above terms and in consideration of the services provided to the below named patient, the undersigned agrees, whether he/she signs as the patient or guarantor, to pay for all services ordered by the providers, or requested by the patient and the patient's family. If requirements for referral, second opinion or precertification of care, as outlined by the insurer, benefit plan or other payor, have not been followed the patient and/or guarantor may, in some instances, be personally responsible for all charges incurred. If an account is forwarded to a collection agency for nonpayment the fees incurred will be charged to the guarantor of the account.

Assignment of Insurance Benefits: In consideration of any and all services furnished, I authorize direct payment to the physician practice all insurance benefits applicable to services rendered by providers which are now or shall become due and payable to me.

Notice of Privacy Practices Acknowledgement of Receipt: I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Missouri Ear, Nose and Throat Center providers and staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Missouri Ear, Nose and Throat Center's operation and responsibilities.

Do you have a Durable Power of Attorney (DPOA)? NO YES (Please enter name below)

Name of DPOA: _____

The undersigned certifies that the conditions of treatment have been read and understood.

Signature of patient/person authorized to consent Printed Name Date

Pain History Questionnaire

PLEASE HIGHLIGHT YOUR ANSWER WHEREVER APPLICABLE

Name: _____Male __ Female __ Date: ___ / ___ / _____

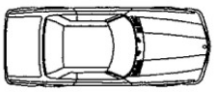
DOB: ___ / ___ / _____ Age (Years): _____ ☐ Dover ☐ Wilmington ☐ Lewes

Please provide the following medical information to the best of your ability:

1. **Describe your main reasons for this visit (Chief Complaint):**

_____
_____
_____

2. Is your pain related to an accident / injury? YES NO When? (Month/Day/Year_____

1. Motor Vehicle Accident? YES / NO Driver / Passenger  Seat Belt / Air Bag Deployed Indicate site of impact: "P" = Primary "S" = Secondary Did you hit your head? YES NO Any loss of consciousness? YES NO Memory Problems? YES NO Police Notified? YES NO Visit to Emergency Room YES NO	**2. Work Related Injury:** YES NO Has this injury been accepted as a Worker's Compensation claim? YES NO

Describe your accident / injury or history of problem in detail:

_____
_____
_____
_____
_____
_____

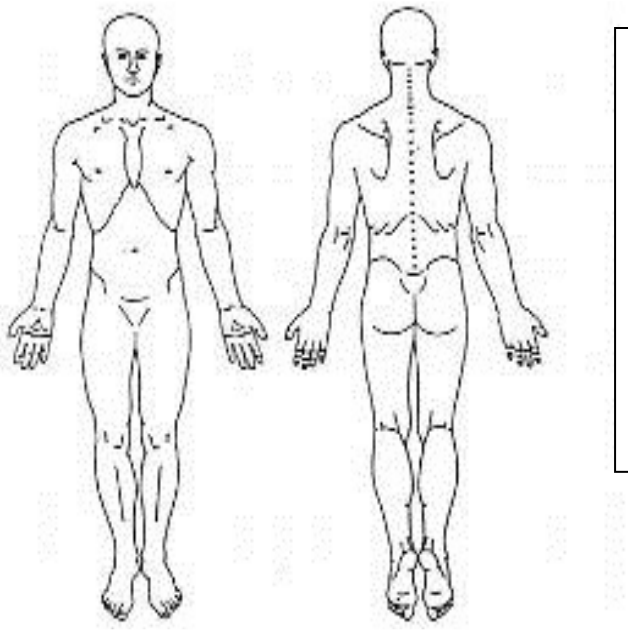
3. Any tests (x-rays, CT Scan, MRI) done to evaluate this problem? YES NO

Tests	Facility Name	Location & Phone	Physician Name	Results
x-ray				
CT Scan				
MRI Scan				
Bone Scan				
EMG Testing				
Other				

4. Other pain management physicians you have consulted? YES NO NA

Physicians Name	Location	Treatment History: Medications, Therapies, Injections (List and Describe)

5. INSTRUCTIONS: Mark these drawings according to where you hurt (if the back of your neck hurts, MARK the drawing on the back of the neck, etc.,)



Type of your pain:

PLEASE CIRCLE YOUR ANSWER:

Burning	Tiring	Nagging
Stabbing	Exhausting	Shooting
Miserable	Unbearable	Sharp
Numb/Tingling	Aching	Tender
Penetrating	Throbbing	

COMMENTS:

1. Please mention the level of your primary pain **from 0 (no pain) to 10 (worst pain imaginable)** for the following:

   PRESENT level of pain:

   WORST pain you've had:

   AVERAGE level of pain (day to day):

2. Your present pain is… Constant Intermittent Worse in the… A.M. P.M.

3. Have your symptoms gotten Worse Better No Change

4. Which of the following activities increase your pain: **PLEASE HIGHLIGHT YOUR ANSWER**

   Sitting Standing Walking Lifting Housework
   Coughing Sneezing Lying flat on back Lying flat on stomach

5. What activities decrease your pain? **PLEASE HIGHLIGHT YOUR ANSWER**
   Sitting Standing Walking Lying flat on back Lying flat on side with knees bent

6. Do you have any pain going down your: Right Arm Left Arm Right Leg Left Leg

7. Do you have difficulty sleeping because of pain? YES NO

8. Please rate your ability to cope with pain:
(0 = Not able, 10= Very able)

9. Please rate your ability to perform activities of daily living, such as hygiene, household chores, transportation, etc.:
(0 = Not able, 10 = Very able)

10. Please rate your ability to function and interact with family and friends:
(0 = Not able, 10 = Very able)

11. Please rate your ability to work in your usual occupation:
(0 = Not able, 10 = Very able)

6. Functional History: PLEASE HIGHLIGHT YOUR ANSWER

Pain is limiting the Activity			**Comments**				**Comments**
Sitting	Yes	No		Squatting	Yes	No	
Standing	Yes	No		Crawling	Yes	No	
Walking	Yes	No		Climbing	Yes	No	
Driving	Yes	No		Repeated arm motions	Yes	No	
Bending	Yes	No		Repetitive use of wrist/hands	Yes	No	
Turn/Twist	Yes	No		Reaching above shoulders	Yes	No	
Kneeling	Yes	No		Foot Controls	Yes	No	
Sleeping	Yes	No		Yard Work	Yes	No	
Appetite	Yes	No		Housework	Yes	No	
Working	Yes	No		Sexual Activity	Yes	No	
Emotion	Yes	No		Other: Specify:	Yes	No	
Concentration	Yes	No					

7. Past Accidents/ Injuries

Injury	Body Part (s) Injured	Treatment	Outcome Completely Healed Residual Pain (%)	Lawyer?	Case Open??
1st Accident Date:				Yes No	Yes No
2nd Accident Date:				Yes No	Yes No
Work Injury: Date:				Yes No	Yes No

8. Pain Medications that you are taking for pain:

Name	Side effects?	Does it help?
		YES NO
		YES NO
		YES NO

9. Medications and other treatments that you have tried in the past <u>PLEASE HIGHLIGHT YOUR ANSWER:</u>

Opioids: Fentanyl (Actiq, Duragesic), Demerol, Hydrocodone (Vicodin, Lortab, Norco), Tramadol, Morphine, Oxymorphone, Methadone, Oxycodone, Hydromorphone, Tapentadol, Propoxyphene (Darvocet), Buprenorphine (Suboxone, Subutex), Codeine

Anti-Inflammatories / Tylenol: Diclofenac, Oxaprozin, Meloxicam, Nabumetone, Aspirin, Indomethacin, Ibuprofen, Acetaminophen, Celecoxib, Etodolac, Naproxen, Flector patch

Muscle Relaxants: Baclofen, Methocarbamol (Robaxin), Carisoprodol (Soma), Cyclobenzaprine (Flexeril), Metaxalone (Skelaxin), Tizanidine (Zanaflex)

Antidepressants: Cymbalta, Nortriptyline, Remeron, Wellbutrin, Effexor, Paxil, Serzone, Zoloft, Amitriptyline, Pristiq, Imipramine (Tofranil), Lexapro, Fluoxetine (Prozac), Trazodone

Sleep Aids: Zolpidem (Ambien), Lunesta, Rozerem, Xyrem, Restoril, Sonata

Other Medications: Axert, Hydroxyzine, Lyrica (Pregablin), Tegretol, Zonegran, Buspar, Imitrex, Maxalt, Topamax, Frova, Keppra, Gabapentin (Neurontin), Vistaril, Gabitril, LIdoderm Patch, Relpax, Zomig, Bupenorphine, Naloxone

Other Herbal Remedies:

Marijuana:

Any other beliefs / Concerns:

10. Pain relieving injections (Spinal Injections) that you have tried in the past?

Name	Side effects?	Did it help?
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO

11. Please list all spine surgeries:

Type of Surgery	When? Where? and Name of Surgeon

12. Please list all other surgeries, excluding the spine:

Type of Surgery	When? Where? and Name of Surgeon

13. Other treatments tried in the past:

Name		Did it help?	
TENS unit		YES	NO
Physical Therapy		YES	NO
Chiropractic Therapy		YES	NO
Massage Therapy		YES	NO
Acupuncture		YES	NO
Counseling		YES	NO
Other (Specify):		YES	NO

14. Describe your treatment expectations:

Non-Opioid Medications?	YES	NO	WILL TRY	Opioid Medications?	YES	NO	WILL TRY
Spinal Injections?	YES	NO	WILL TRY	Spinal Surgery?	YES	NO	WILL TRY
Therapies?	YES	NO	WILL TRY	Acupuncture?	YES	NO	WILL TRY
Marijuana (***SELF PAY***)	YES	NO	WILL TRY	TMS -Brain Stimulation?	YES	NO	WILL TRY

15. Some of the pain medications make patients to become dependent and at time make them addicted to the medications. Are you aware of such issues? **YES** **NO**

16. Are you aware of any of your family members, friends and relatives who have experienced problems with prescription medication dependency and addiction? **YES** **NO**

If YES, Your comments:

_____

17. Willing to change your prescription medications if suggested? **YES** **NO** **WILL TRY**

18. Past Medical History:

Diabetes	Yes	No		Thyroid Problems	Yes	No	
High Blood Pressure	Yes	No		Allergy Problems	Yes	No	
Heart Disease	Yes	No		Kidney / Bladder / Prostate	Yes	No	
Heart Attack	Yes	No		Neurological problems	Yes	No	
Heart Surgery	Yes	No		Addiction /Substance abuse	Yes	No	
High Cholesterol	Yes	No		Mental Health / Psychiatric	Yes	No	
Respiratory Problems	Yes	No		Other:	Yes	No	
Stomach Problems	Yes	No		Bleeding DisorderS	Yes	No	

19. Regular medications if any: (ex: for blood pressure, diabetes, ulcers, BLOOD THINNERS,)

Name	Dose	Prescribed By?	Side Effects?	Comments

20. Please list any **Drug Allergies:**

Name	Reaction	Name	Reaction

IV Dye Allergy: **YES** NO Latex Allergy: **Yes** NO Seafood / Shell Fish Allergy: **YES** NO

21. Family History

Disease	**YES**	**NO**	**Relationship**	**Disease**	**YES**	**NO**	**Relationship**
Diabetes				Alcohol Addiction			
Hypertension (high blood pressure)				Tobacco Addiction			
Cardiac problems				**Prescription Drug Addiction**			
Bleeding Disorder				**Substance abuse/Illicit drugs (Heroin, Cocaine etc)**			
Cancer				**Anesthesia problems**			
Arthritis (Rheumatoid, Psoriasis etc)				**Chronic Pain Problems (Low back, Neck etc)**			
Respiratory problems				Other medical diagnosis			

Are you currently: ☐ Single ☐ Married ☐Widowed ☐ Divorced ☐Separated?

Is your significant other working? ☐YES* ☐NO *Type of work: _____

Where do you live? ☐Trailer Home ☐Apartment ☐2+ Story House ☐Ranch-style

Transportation? ☐Own a car ☐Friends car ☐Public Transport ☐Family member

22. Social History:

	YES	**NO**	**Comments**		**YES**	**NO**	**Comments**
Smoking				Working- Full Time			
Drinking				Working- Part Time			
Marijuana *(Regular or Recreational)*				Retired			
Cocaine				Applying for Disability			
IV drug usage (Heroin etc)				On Short Term Disability			
Incarceration (Arrests etc)				Disabled (Social Security)			

23. If you are not working now, do you see yourself?

☐Returning to the same job ☐Modified work ☐Changing jobs - same employer

☐Changing jobs - different employer ☐Job Retraining or returning to school

24. Review of Systems: ***Height: ____Weight: _____ BMI: _____***

GENERAL:	Change of Appetite	Weight Loss or Gain	Fatigue	Fever	
NEURO:	Weakness	Numbness	Tingling	Headaches	Tremors
GI:	Nausea	Vomiting	Reflux	Constipation	Diarrhea
PSYCH:	Depression	Anxiety	Memory Loss	Sleeplessness	Mood Changes
MUSCULO-SKELETAL:	Spasms	Cramps	Joint Pain	Swelling	Stiffness
RESPIRATORY:	Cough	Breathless	Chest Pain		
CARDIAC:	Chest Pain	Palpitations	Leg Edema		
ENDOCRINE:	Hot or Cold Intolerance	High Sugar	Excess Thirst	Increased Urination	
ENT:	Change in Vision	Decreased Hearing	Change in Voice		
GU:	Loss of Bladder	Increased Frequency	Kidney Stones		

25. I certify that the above information is true to the best of my knowledge.

Print Name: _____ INITIALS: _____ Date: _____

DR. GANESH BALU'S OFFICES **DAST -10 QUESTIONNAIRE**

Patient Name: _____ Date: _____

Read the following questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: Cannabis (e.g., Marijuana, Hash), Solvents, Tranquilizers (e.g., Valium), Barbiturates, Stimulants (e.g., Cocaine, Speed), Hallucinogens (e.g., LSD) or Narcotics (e.g., Heroin). Remember that the questions **do not include alcohol or tobacco.**

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months.	**NO**	**YES**
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? If never use drugs, answer "Yes."	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose No.	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you engaged your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Interpreting the DAST-10

In these statements, the term "drug abuse" refers to the use of medications at a level that exceeds the instructions, and/or any non-medical use of drugs. Patients receive 1 point for every "yes" answer with the exception of question #3, for which a "no" answer receives 1 point. DAST-10 Score Degree of Problems Related to Drug Abuse Suggested Action.

DAST-10 Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

DR GANESH BALU'S OFFICES **Opioid Risk Tool**

Patient Name: _____ Date: _____

This tool should be administered to patients upon initial visit/ prior to continuing opioid therapy for pain management.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals: **<3 = Low Risk** **4-7 = Moderate Risk** **>8 = High Risk**		

SOAPP Version 1.0-14Q

Please answer the questions: **0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

How often do you have mood swings?	0	1	2	3	4
How often do you smoke a cigarette within an hour after you wake up?					
How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?					
How often have any of your close friends had a problem with alcohol or drugs?					
How often have others suggested that you have a drug or alcohol problem?					
How often have you attended an AA or NA meeting?					
How often have you been treated for an alcohol or drug problem?					
How often have your medications been lost or stolen?					
How often have others expressed concern over your use of medications?					
How often have you felt a craving for medication?					
How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?					
How often have you been asked to give a urine screen for substance abuse?					
How often, in your lifetime, have you had legal problems or been arrested?					
How often have you taken medications other than the way that it was prescribed?					
Total Score:					
Sum of questions:	**> Or = 7 positive**	**< 7 Negative**			

Opioid and Controlled Medications Treatment Agreement - Dr. Balu's Offices

I agree to obtain all of my medications from the following pharmacy. I will notify any changes.

Pharmacy _____ Phone: _____ Location: _____

I provide consent for the provider receive and release, disclose and discuss all diagnostic and treatment details with physicians, pharmacists, professionals, institutions and law enforcement agencies for purposes of verifying and maintaining accountability by all communication means.

I consent to the provider obtaining information from State Prescription Monitoring Programs.

I recognize the potential for addiction, abuse and misuse while taking these medications. I will safely protect my medications from damage, loss, theft, children, family members, friends and pets by keeping it in a safe and secure place. I will not share, dispose or divert the medications. I will report stolen prescriptions to the local police immediately and will not expect replacement. I will notify the provider before filling medications from other providers, walk in clinics, emergency rooms, inpatient and outpatient detox centers. I will not call for prescriptions after hours, holidays and on weekends. I will take medications-dosage, number and frequency as prescribed and agreed upon and will not take extra doses, run out or request early refills. I will inform provider office of any new medications or medical conditions, and adverse effects that I experience from any of the medications prescribed. I will safely dispose unused medications at one of the prescription medication drop boxes.

I agree that these medications may have serious side effects that include but not limited to the risks for misuse, abuse, tolerance, dependence, withdrawal symptoms, addiction, worsening of pain, respiratory depression, sleep apnea, impaired driving, impaired ability to operate machinery, sleepiness, slow thinking, mental confusion, bad dreams, hallucinations, constipation, itching, sweating, nausea, vomiting, decreased sex hormones, irregular menstrual periods, depression, dry mouth with tooth decay, allergies, poor immune system etc., When taken irresponsibly and in combination with alcohol, illicit drugs, other supplements, psycho active prescription drugs, addictive drugs like benzodiazepines (i.e. Xanax and Valium), muscle relaxants (i.e. Soma or Flexeril), sleeping pills or hypnotics (i.e. Ambien or Lunesta) and other opioid pain medications, there is increased chances of overdose that can potentially be fatal.

I understand that I have to answer all questionnaires honestly and to the best of my understanding and will not withhold relevant information. I agree to appear for my scheduled appointments as required and also appear for unscheduled appointments for random drug screens and pill counts. I consent to bringing original containers of medications to office visits and also consent to provide urine, saliva or blood as required. I am aware that these tests may be imposed at additional costs if there are any restrictions imposed by my insurance.

I understand that it is not safe to drink alcohol or use illegal street drugs that include but not limited to cocaine, heroin, LSD, Marijuana etc., use diverted or shared prescription drugs, psychiatric drugs, inhalants, synthetic drugs like ecstasy etc.,

I understand that I am restricted to type, dosage, frequency and quantity limits as imposed by my health insurance company. I understand that the provider does not override, authorize self pay or get prior authorizations from my insurance company for overused, non-covered and non-formulary medications. If I exceed the allowed amount, I will be responsible for the cost of paying for the medication.

I understand and consent to participate in the comprehensive pain management program and receive potential benefits from any and all other treatments like non opioid medications, adjuvant medications, various rehabilitative therapies, counseling, spinal injections, counseling etc., and not just medications as on their own they will not eliminate pain**.** I understand that renewals are contingent on keeping scheduled appointments for all of my comprehensive pain management care.

I consent for the provider to involve my spouse, significant other, immediate family member or friends to discuss my treatment and compliance with the medications and take appropriate action.

I understand that these medications during pregnancy can harm the unborn baby. Provider may alter plan of care to protect my health and the health of the unborn baby.

I agree that treatments are initially a trial, and that continued prescriptions are contingent upon evidence of reported or proven effectiveness and benefit. If the risks and side effects outweigh the benefits, provider may change, taper or discontinue the medications. If goals of the treatment were to change over time, I will sign another consent form for these changes. I will comply with provider efforts to follow all local, state and federally mandated rules, regulations and guidelines.

I understand and voluntarily agree that failure to meet any one or various requirements noted in this agreement may result in my provider choosing to change, taper or discontinue the medication in addition to imposing other specialist referrals. I have been offered a copy of this agreement.

Patient Signature: _____

Date: _____

Suboxone Treatment Agreement - Dr. Balu's Offices

I agree to obtain all of my medications from the following pharmacy. I will notify any changes.

Pharmacy _____ Phone: _____ Location: _____

I hereby provide consent for the provider to receive, release, disclose and discuss all diagnostic and treatment details with physicians, pharmacists, professionals, institutions and law enforcement agencies for purposes of verifying and maintaining accountability by all communication means.

I give consent to the provider to obtain information from State Prescription Monitoring Programs, pharmacies, physicians, hospitals, walk-in clinics, detox centers and any other sources.

I understand that Suboxone (buprenorphine/naloxone in combination) has the same addictive properties as other opiates, such as heroin, methadone, codeine, morphine and oxycontin. Stopping Suboxone suddenly will result in the same withdrawal symptoms and put me at the same risk of relapse as with other opiates.

I recognize the potential for addiction, abuse and misuse while taking these medications. I will safely protect my medications from damage, loss, theft, children, family members, friends and pets by keeping it in a safe and secure place. I will not share, dispose or sell/giveaway the medications. I will report stolen prescriptions to the local police immediately and will not expect replacement. I will notify the provider before filling medications from other providers, walk in clinics, emergency rooms, inpatient and outpatient detox centers. I will notify the provider regarding my history of overdoses and history of Naloxone used to revive such near death situations. I will not call for prescriptions after hours, holidays and on weekends. I will take medications-dosage, number and frequency as prescribed and agreed upon and will not take extra doses, run out or request early refills. I will inform provider office of any new medications or medical conditions, and adverse effects that I experience from any of the medications prescribed. I will safely dispose unused medications at one of the prescription medication drop boxes.

I agree that these medications may have serious side effects that include but not limited to the risks for misuse, abuse, tolerance, dependence, withdrawal symptoms, headache, insomnia, pain, asthenia, nausea, constipation, diaphoresis, diarrhea, rhinitis, depression, anxiety, dizziness/vertigo, vasodilatation, rigors, vomiting, oral mucosa erythema etc., When taken irresponsibly and in combination with alcohol, illicit drugs, other supplements, psycho active prescription drugs, addictive drugs like benzodiazepines (example: Xanax and Valium), muscle relaxants (example: Soma or Flexeril), sleeping pills or hypnotics (example: Ambien or Lunesta) and other opioid pain medications (example: Vicodin, Percocet) there is increased chances of overdose that can potentially be fatal.

I understand that I have to answer all questionnaires honestly and to the best of my understanding and will not withhold relevant information. I agree to appear for my scheduled counseling and doctor appointments as required and also appear for unscheduled appointments for random drug screens and pill/films/wrapper counts. I consent to bringing original containers of medications to office visits and also consent to provide urine, saliva or blood as required. I am aware that these tests may be imposed at additional costs if there are any restrictions imposed by my insurance.

I understand that it is not safe to drink alcohol or use illegal street drugs that include but not limited to cocaine, heroin, LSD, Marijuana etc, use diverted or shared prescription drugs, psychiatric drugs, inhalants, synthetic drugs like ecstasy etc.,

I understand that I am restricted to type, dosage, frequency and quantity limits as imposed by my health insurance company. I understand that the provider does not override, authorize self pay or get prior

authorizations from my insurance company for over used, non-covered and non-formulary medications. If I exceed the allowed amounts I will be responsible for the cost of paying for the medication. I understand and consent to participate in the comprehensive pain management/addiction treatment program and receive potential benefits from any and all other treatments like non opioid medications, adjuvant medications, various rehabilitative therapies, substance abuse counseling, spinal injections, mental health counseling etc., I understand that renewals are contingent on keeping scheduled appointments for all of my comprehensive pain management care.

I consent for the provider to involve my spouse, significant other, immediate family member or friends to discuss my treatment and compliance with the medications and take appropriate action.

I understand that these medications during pregnancy can harm the unborn baby. Provider may alter plan of care to protect my health and the health of the unborn baby.

I agree that treatments are initially a trial, and that continued prescriptions are contingent upon evidence of reported or proven effectiveness and benefit. If the risks and side effects outweigh the benefits, provider may change, taper or discontinue the medications. If goals of the treatment were to change over time I will sign another consent form for these changes. I will comply with provider efforts to follow all local, state and federally mandated rules, regulations and guidelines.

I understand and voluntarily agree that failure to meet any one or various requirements noted in this agreement may result in my provider choosing to change, taper or discontinue the medication in addition to imposing other specialist referrals. I have been offered a copy of this agreement.

Patient Signature: _____ Counselor Signature: _____

Date: _____ Date: _____