ALBERT LAI, M.D.
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AHMED HAGGAG, PA-C
ROXANNE MANUEL, PA-C
ELIZABETH KELIIHOLOKAI, PA-C

Dear_____

Welcome! Thank you for choosing our office to assist you with your rehabilitation. This letter is to confirm your appointment on _____.

****You must arrive 30 minutes early at the following location or your appointment may be rescheduled:**

☐ 1041 E. YORBA LINDA BLVD.
SUITE 210
PLACENTIA, CA 92870

☐ 1010 W. LA VETA
SUITE 615
ORANGE, CA 92868

☐ 2 JOURNEY
SUITE 200
ALISO VIEJO, CA 92656

☐ 22821 LAKE FOREST DR.
SUITE 115
LAKE FOREST, CA 92630

☐ 26700 TOWNE CENTRE DR.
SUITE 110
FOOTHILL RANCH, CA 92610

For your convenience, our patient packet will be mailed to you. Please bring this packet with you to your appointment fully completed. <u>If not completed, your appointment may be rescheduled.</u>

Please bring the following items to your appointment:

- ☐ ***Photo ID & Insurance Card***
- ☐ ***All Current prescription medication bottles***
- ☐ ***Copies of radiology reports + films / MRI / X-rays***
- ☐ ***Reminder: We do NOT accept checks for copays.***
  For your convenience, we accept cash, Visa & Mastercard

Should you require additional assistance or have questions regarding this information, please do not hesitate to contact us at (714) 223-7000.

Once again, we look forward to meeting you.

OUTSIDE MEDICAL RECORDS PROTOCOL

Thank you for choosing Centers of Rehabilitation and Pain Medicine to assist you with your rehabilitation. We are committed to providing you with the best possible care and treatment.

To be able to provide you with proper treatment we must have medical records outlining your recent medical care to include office visit notes, radiology testing, lab results and medication lists.

We must have copies of your medical records in our office prior to your appointment. If you have been referred by another medical office, we will call them to request your medical records be sent to our office prior to your appointment.

If you are obtaining the medical records, they must be provided to our office no later than the *day before* your appointment. You may fax them to 714-223-7001. If you choose to fax records, please notify our office at 714-223-7000, so we can let you know if we do not receive them.

If we do not receive medical records prior to your appointment, we will be unable to write any medications for you until we do receive them.

You may call our office at 714-223-7000 the day before your appointment to verify we have received your records.

If you choose not to provide us with records, you must have a medical work up possibly to include: radiology testing, electrical studies and lab work before we will be able to safely right you prescriptions for medications.

Thank you for your understanding and cooperation,

Management

Centers of Rehabilitation & Pain Medicine
9/29/17

CRPM

Centers of **R**ehabilitation and **P**ain **M**edicine

Albert Lai, MD Charles S. Daniels, MD David W. Lee, MD Shinto Koshy, MD

Ahmed Haggag PA-C Roxanne Manuel PA-C Elizabeth Keliiholokai PA-C

OFFICE: 714-223-7000 FAX: 714-223-7001

AUTHORIZATION TO RELEASE INFORMATION

Patient Name (Last)_____ (First)_____

DOB: _____ SS#: _____

Cell # ( ) _____ Day Phone # ( ) _____

INFORMATION REQUESTED ***FROM:***

Name: _____

Address: _____

State: _____ Zip Code: _____

Phone: ( ) _____ FAX: ( )_____

INFORMATION REQUESTED ***TO:***

Name: _____

Address: _____

State: _____ Zip Code: _____

Phone: ( ) _____ FAX: ( )_____

Information I would like sent / requested:

_____ Copies of pertinent info only (H&P, OP reports, Labs, Imaging Reports)

_____ Copy of entire medical record

_____ Other (Please Specify)_____

Patient Signature: _____ Date: _____

Please send to ***FAX# 714-223-7001*** or

Mail to: 1041 E. Yorba Linda Blvd. Suite #210, Placentia, CA 92870

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PATIENT REGISTRATION

LAST NAME: _____

FIRST NAME: _____ MIDDLE NAME :_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

SEX: M F DRIVERS LICENSE #:_____ STATE: _____

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

RACE: _____ ETHNICITY: _____

PARENT/GUARDIAN NAME (if patient is a minor): _____

RELATIONSHIP TO MINOR: _____

HOME STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

*PLEASE INDICATE BELOW WHICH IS YOUR PRIMARY PHONE NUMBER

☐ HOME PHONE:_____ ☐ CELL PHONE:_____

May our office leave a message on your primary voicemail? YES NO

EMAIL ADDRESS:_____

EMPLOYER:_____OCCUPATION:_____

WORK ADDRESS:_____

EMERGENCY CONTACT (OTHER THAN YOUR OWN)

NAME:_____ PHONE NUMBER:_____

Primary Insurance:

NAME OF PRIMARY INS CO:_____ PHONE:_____

ID/POLICY NUMBER:_____ GROUP NUMBER:_____

SUBSCRIBER/INSURED:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

INSURED EMPLOYER NAME:_____

EMPLOYER PHONE:_____

Secondary Insurance:

NAME OF SECONDARY INS CO:_____ PHONE:_____

ID/POLICY NUMBER:_____ GROUP NUMBER:_____

SUBSCRIBER/INSURED:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

INSURED EMPLOYER NAME:_____

EMPLOYER PHONE:_____

General Medical Consent: The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to x-ray examinations, laboratory procedures and medical services rendered to patient under the general and special instructions of the physician. It is understood that the patient is under the care and supervision of his/her attending physician.

I, the undersigned, assign directly to the Office of Albert Lai, M.D. all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I will be required to present my health insurance card and driver's license to ensure coverage and identity. I hereby authorize the doctor to release all information necessary to secure payment of benefits. Should my insurance deny payment I am fully aware that I am responsible for all charges incurred.

_____ _____

Signature of Patient, Parent, Legal Guardian or Legal Representative Date

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Financial Policy

We want to welcome you to our office. We are committed to providing you with the best possible care and we will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions that you may have about our fees, financial policy or your responsibilities.

We cannot bill your insurance unless you bring your complete insurance information with you. Our office will bill your insurance as a courtesy, but ultimately the balance is your responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. **If you have a co-payment with your insurance it is due at the time of service or we will charge you a $15 billing fee per missed co-payment.** You may choose to pay by cash, Visa or Mastercard. It is necessary for you to verify your benefits through your insurance, as some services may be considered "non-covered" or may have a benefit limitation.

Auto Accidents— We will bill your auto insurance if you have "Med Pay" on your policy. **If you are represented and you lose your case you are fully responsible for all charges.**

Medicare Clients— Medicare will pay 80% of the acceptable charges. If you have a secondary insurance, we will bill them for the remaining 20% If you do not have a secondary insurance, the balance will be due and payable by you. You will receive a statement for your portion after Medicare has completed their payments.

I have fully read the above and fully understand and agree to the terms of this policy. I hereby assign all medical benefits to the Offices of Albert Lai, M.D. I understand I am personally responsible for all legitimate charges incurred, regardless of insurance coverage.

_____ _____

Responsible Party Signature Date

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POLITICA FINANCIERA

Queremos darle una cordial bienvenida a nuestra oficina. Estamos comprometidos a proveerle con el mejor cuidado posible y será un gusto atenderle para hablar sobre nuestros honorarios profesionales en cualquier momento. La Comprensión clara de nuestra política financiera es muy importante para nuestra relación profesional. Por favor no dude en preguntar cualquier duda que pueda tener sobre nuestros honorarios o política financiera sobres sus responsabilidades.

No podremos facturar a su aseguradora a menos que usted traiga consigo toda su información completa. Nuestra oficina facturará a su aseguradora como una cortesía, pero finalmente el saldo a pagar será responsabilidad de usted. Su póliza de seguro es un contrato entre usted y su compañía aseguradora; nosotros no somos parte de ese contrato. **Si usted tiene un coaseguro con su aseguradora este es exigible al momento del servicio, o le cobraremos una comisión de facturación de $15 por coaseguro no pagado.** Puede elegir pagar en efectivo, Visa o Mastercard. Es necesario que usted verifique sus beneficios con su aseguradora, ya que algunos servicios pueden ser considerados "no cubiertos" o tener beneficios limitados.

Accidentes Automovilísticos - Nosotros facturaremos a su seguro de auto si usted tiene "Med Pay" en su póliza. **Si usted es representado por un abogado y pierde su caso, usted es responsable por todos los cargos en su totalidad.**

Clientes de Medicare - Medicare pagará el 80% de los cargos que sean aceptables. Si usted tiene un seguro secundario les facturaremos a ellos el 20% restante. Si no tiene este seguro secundario, este saldo será exigible inmediatamente y será pagado por usted. Recibirá un estado de cuenta con este saldo después de que Medicare haya completado su pago.

He leído y entendido completamente todo lo anterior y acepto los términos de esta política. Por la presente cedo todos los beneficios médicos a Offices of Albert Lai, M.D. Entiendo que soy personalmente responsable por todos los cargos legítimos incurridos, independientemente de la cobertura de mi seguro.

_____ _____

Firma de la parte responsible Fecha

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PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION - (HIPAA)

I, _____ understand the Offices of Albert Lai, M.D., is not authorized by me to use or disclose my protected health information for purpose other than treatment, or health care operations.

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of the Offices of Albert Lai, M.D., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply)

☐ The patient's entire medical record (NOTE: This requires an explanation why the entire record may be disclosed) The patient's demographic information (check all that apply)

☐ Name	☐ Street/Zip Code Only	☐ Specific condition(s)
☐ Address	☐ Telephone	☐ Specific medication(s)
☐ Age	☐ Gender	☐ Specific professional service(s)
☐ Race		

☐ Other _____
_____
_____

Name of person(s) other than myself authorized by this form to use and disclose the protected health information (family members, etc)_____
_____
_____ I authorize the Offices of Albert Lai, M.D. to contact me by mail or phone regarding information or services that may be helpful or beneficial to me.

Signature:_____ Date: _____

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AUTORIZACIÓN DEL PACIENTE PARA USAR O REVELAR INFORMACIÓN PROTEGIDA DE SALUD - (HIPAA)

Yo _____ Entiendo que los Offices of Albert Lai, M.D. no están autorizados por mí para uso o revelación de mi información protegida de salud para un propósito que no sea el tratamiento u operaciones de atención médica.

He leído esta autorización y entiendo que información será utilizada o revelada, quien podra utilizar y revelar la información y el destinatario (s) de esa información. Autorizo específicamente a cualquier empleado o dueño de Offices of Albert Lai, M.D., o cualquier otra persona que se enumere a continuación a revelar mi información médica protegida como se describe en este formulario a los destinatarios mencionados a continuación. Yo entiendo que cuando se utilice o revele la información conforme a esta autorización, puede ser objeto de revelación por parte del destinatario y podrá terminar no siendo informacion protegida sobre la salud. Entiendo que conservo el derecho de revocar esta autorización, si se hace de acuerdo a los pasos se establecen a continuación.

Descripción de la información a ser utilizada o revelada (marque todo lo que corresponda)

☐ El historial clínico completo del placiente (NOTA: Esto requiere una explicación de por qué todo el registro debe ser revelado)
☐ La información demográfica del paciente (marque todo lo que corresponda)
☐ Nombre ☐ Calle / sólo Código postal ☐ condición específica(s)
☐ Direccion ☐ Teléfono ☐ medicamento(s) específicos
☐ Edad ☐ Género ☐ medicación específica(s)
☐ Raza ☐ servicio(s) profesional(es) específicos
☐ Otro _____
_____
_____

Nombre de la(s) persona(s) ademas de mi, autorizados en esta forma para utilizar y reveler información protegida de salud (miembros de la familia, etc) _____
_____
_____Yo autorizo a Offices of Albert Lai, M.D., para ponerse en contacto conmigo por correo o por teléfono con respecto a información o servicios que puedan ser útiles o beneficiosos para mí.

Firma: _____ Fecha: _____

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Patient Reschedule, Late Arrivals, and Cancellation Policy

In order for us to continue to provide the highest quality service and to minimize your wait time, it is requested that you give **24** hour notice, should you need to reschedule or cancel an appointment.

NEW Patients, please arrive to your appointment **30** minutes prior to your scheduled appointment.
ESTABLISHED Patients, please arrive to your appointment **15** minutes prior to your scheduled appointment.

Patients arriving **10** minutes or after late for a scheduled appointment will be rescheduled.

A "no-show" policy which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24-hour notice.

Patients arriving **15** minutes or more after their scheduled appointment will be considered as a "no-show" and will be rescheduled at another time, in addition:

- First occurrence – Patient/parent will receive a letter advising of our policy.
- Second occurrence – Patient/parent will receive a 2nd letter and a $50.00 no show fee assessment
- Third and subsequent occurrences – May result in dismissal from practice and additional $50 no show fee

I understand that I may be charged a $50.00 fee for each cancelled/no show appointment where a 24 hour notice has not been provided.

Patient Signature:_____

Patient Name (Please Print):_____

Date:_____

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Política de Cancelación o Faltar a su Cita

Para que podamos continuar ofreciendo servicio de alta calidad, se le pide un aviso de 24 horas cuando necesite cambiar o cancelar una cita.

Yo entiendo puedo ser responsable de un recargo adicional de $50 por cada cancelación/ faltar a su cita sin previo aviso de 24 horas.

Firma del paciente:_____

Nombre del paciente (Letra de molde):_____

Fecha:_____

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New Patient Questionnaire

Name:_____ Age: _____ Sex: _____

Current Problem:_____

Any imaging studies for this problem? ☐ **Yes** ☐ **No**

Who referred you? _____

Who is your primary provider / doctor? _____

History of Present Illness (history of painful situation / description of pain)

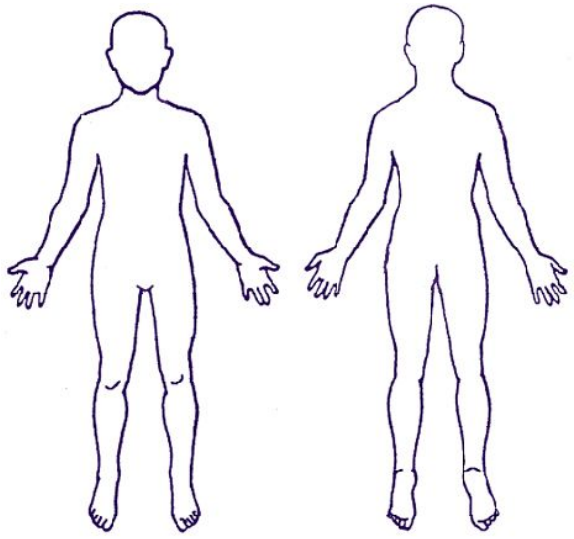
_____

_____

_____

****Where is the pain? Please mark on the drawing where you feel pain right now. Use the key below.**

Front **Back**



Pins & Needles = o o o
Stabbing = / / /
Burning = X X X
Deep Aches = Z Z Z

Rate Your Pain:

0 = No Pain 10 = Worst Pain Ever

1. Right now: 1 2 3 4 5 6 7 8 9 10
2. At Best: 1 2 3 4 5 6 7 8 9 10
3. At Worst: 1 2 3 4 5 6 7 8 9 10

Describe Your Pain: **Dull Sharp Aching Stabbing Burning Shooting Tingling Numbness**

How does the pain change with: Worse (W) Better (B) No Change (O)

Sitting:____ Standing:____ Bending Backwards:____ Bending Forwards:_____ Laying Down:____

Walking:____ Twisting:____ Sneezing:____ PT:____ Massage:____ Medications:____

Other:_____ How long can you: Sit _____ min Stand_____min

Height:_____ Weight: _____

Allergies / Sensitivities:

Please list any reaction you may have or had to any medications:

Medication:	Reaction:
_____	_____
_____	_____
_____	_____

Medication:

Please list all medications you are currently taking:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently seeing any other medical doctors for your painful condition?

Please list their names and phone numbers:

Name:	Phone:
_____	_____
_____	_____

Please write down any X-rays, MRIs, CAT Scans, EMG (Nerve tests) and any other tests you have had:
(please enclose copies of the results, including films if you have them, if not please list body part, facility, and telephone number)

Facility:	Phone:	Image:
_____	_____	_____
_____	_____	_____
_____	_____	_____

What Medical Treatment Have You Had:

	Dates:	Did this help your pain?	
☐ **Physical Therapy**	_____	☐ **YES** ☐ **NO**	**How many times?** _____
☐ **Psychologist**	_____	☐ **YES** ☐ **NO**	**Name:** _____
☐ **Spine Injection**	_____	☐ **YES** ☐ **NO**	**Procedure:**_____
☐ **Trigger Point Injections**	_____	☐ **YES** ☐ **NO**	
☐ **T.E.N.S. (Nerve Stimulator)**	_____	☐ **YES** ☐ **NO**	
☐ **Heat/ Ice Treatment**	_____	☐ **YES** ☐ **NO**	
☐ **Acupuncture**	_____	☐ **YES** ☐ **NO**	
☐ **Chiropractic Therapy**	_____	☐ **YES** ☐ **NO**	
☐ **Other**	_____	☐ **YES** ☐ **NO**	

Does the pain limit your activities of daily living? ☐ **YES** ☐ **NO**

If yes, what percent of the day? ☐ **10%** ☐ **25%** ☐ **50%** ☐ **75%** ☐ **100%**

Self Care: ☐ **Showering** ☐ **Hair Brushing** ☐ **Teeth Brushing** ☐ **Putting on clothes**

Communication: ☐ **Speaking** ☐ **Writing** ☐ **Typing**

Physical Activity: ☐ **Walking Stairs** ☐ **Walking** ☐ **Standing** ☐ **Sitting**

Sensory Function: ☐ **Hearing** ☐ **Seeing** ☐ **Feeling** ☐ **Tasting** ☐ **Smelling**

Hand Activity: ☐ **Lifting** ☐ **Grasping** ☐ **Turning Pages** ☐ **Feeling Things**

Travel: ☐ **Driving a Car** ☐ **Turning head to look in mirror** ☐ **Pain with sitting** ☐ **Pain with bumps in road**

Sexual Function: ☐ **Performing** ☐ **Erection** ☐ **Ejaculation** ☐ **Enjoying**

Past Medical History: (Check Box) Specify If Known

☐ **Heart Disease/Attack** ☐ **Diabetes** ☐ **Lung Problems:**_____

☐ **High Blood Pressure** ☐ **Seizures** ☐ **Cancer:**_____

☐ **TIA/Stroke** ☐ **Thyroid:**_____ ☐ **HIV:**_____

☐ **Bleeding Problems** ☐ **Hepatitis:**_____ ☐ **Kidney Stones**

☐ **Stomach/Intestine:**_____

☐ **Other:**_____ ☐ **Other:**_____

☐ **Other:** _____ ☐ **Other:**_____

Surgical History:

☐ **Appendectomy** ☐ **Tonsillectomy**

☐ **C-Section** ☐ **Spine Surgery:**_____

☐ **Hysterectomy** ☐ **Joint Replacement:**_____

☐ **Hernia Repair** ☐ **Arthroscopy:**_____

☐ **Carpal Tunnel Surgery** ☐ **Surgery Fracture Repair:**_____

☐ **Gall Bladder** ☐ **Other:**_____

☐ **CABG** ☐ **Other:**_____

☐ **CA/Stent** ☐ **Other:**_____

Family History:

Any family medical problems?_____

Social History:

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** Children? ☐ **YES #:**____ ☐ **NO**

Do you drink alcohol (beer, wine, etc)? ☐ **NO** ☐ **YES** ☐ **Daily** ☐ **Weekly** ☐ **Monthly**

Do you smoke cigarettes? ☐ **YES** ☐ **NO** How many packs/day?_____

Do you or have you ever used recreational drugs? ☐ **YES** ☐ **NO**

What kind and how often? _____

Review of Systems - Any problems with: (Check Box)

☐ **Chills**	☐ **Palpitations**	☐ **Back Pain**	☐ **Headaches**
☐ **Sweats**	☐ **Cough**	☐ **Joint Stiffness**	☐ **Numbness/Tingling**
☐ **Fevers**	☐ **Shortness of Breath**	☐ **Joint Swelling**	☐ **Limb Weakness**
☐ **Weight Loss**	☐ **Abdominal Pain**	☐ **Leg Swelling**	☐ **Easy Bruising/Bleeding**
☐ **Weight Gain**	☐ **Constipation**	☐ **Exposure to TB**	☐ **Vision Changes**
☐ **Depression**	☐ **Diarrhea**	☐ **Rash/Lesions**	☐ **Hearing Problems**
☐ **Stress**	☐ **Itching**	☐ **Anxiety**	☐ **Incontinence Urine/Stool**
☐ **Chest Pain**	☐ **Blood in Stool**	☐ **Dizziness**	☐ **Sleep**

Current Work Status:

Job Title/Description: _____

☐ **Full Time** ☐ **Part Time** ☐ **Student** ☐ **Homemaker** ☐ **Retired** ☐ **Other**_____

☐ **Unemployed, Disabled** ☐ **Unemployed, Not Disabled**

☐ **Length of time unemployed:_____years _____months**

☐ **Working with restrictions: Occupation: _____ Restrictions: _____**

Are you unemployed/underemployed because of your injury? ☐ **YES** ☐ **NO**

Past Injuries or Accidents:

Accident:

Date: _____ Body Part Injured: _____

What happened? _____

Did you get medical treatment? ☐ **YES** ☐ **NO** Did you make a full recovery? ☐ **YES** ☐ **NO**

Has the injury affected your ability to work/ Do you have current restrictions?

_____

Work Related Injury:

Date: _____ Body Part Injured: _____

Have you ever hurt this part before? ☐ **YES** ☐ **NO** How: _____

_____

Did you get medical treatment? ☐ **YES** ☐ **NO** Who first treated you: _____

Where: _____ Who has treated you since: _____

Did you make a full recovery? ☐ **YES** ☐ **NO**

Has the injury affected your ability to work / Do you have current restrictions? _____

Date you last worked: _____ Date you started with your employer: _____

What were your job duties and hours? _____

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LONG-TERM CONTROLLED SUBSTANCES THERAPY FOR CHRONIC PAIN

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives are controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies **are agreed to by you,** the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or confirmed prescription of controlled substances to treat your chronic pain.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to, using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking pain medicines can cause symptoms like bad flu, called a withdrawal symptom. I agree not to take any of these medicines and to tell any doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history, as well as that of my family, to the best of my knowledge.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absences, by the covering physician, unless specified authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.) **Obtaining medications from other healthcare providers without the knowledge of**

<u>your physician at the Offices of Albert Lai, M.D. can lead to a discharge and an inability to obtain narcotic prescriptions.</u>

2. **All controlled substances must be obtained at the same pharmacy, where possible.** Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____ location & phone: _____
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, trade, sell, or otherwise permit others to have access to these medications.
6. **I agree to take the medications as prescribed.** If I do take more than directed and will run out early, I will notify my physician and I may be asked to come for a discussion. I will not call 'at the last minute' and request medications when you're about to run out early when you have failed to notify the doctor and the Offices of Albert Lai, M.D. in a timely manner.
7. These drugs should not be stopped abruptly, as a withdrawal syndrome will develop.
8. **Unannounced urine toxicology screens may be requested, and your cooperation is required.** Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
9. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
10. Original Containers of medications should be bought in to the office when requested.
11. Since the drug may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
12. **Medications will not be replaced if they are lost, get wet, are destroyed, misplaced (i.e. left on an airplane), etc… If you medication has been stolen and you complete a police report regarding the theft, an exception may be made after we discuss the situation with you and/or the police.**
13. **Early refills will not be given unless the physician authorizes this on a case by case basis, there is a change in condition, or the exception as described above.**
14. Prescriptions may be issued early if the physician will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they may not be filled prior to the appropriate date. In some cases, extra medication may be given for the sole purpose of giving you enough to last until you return. However, this does not mean that you can take extra during the course of your monthly regimen.
15. I do not use or distribute any illegal or illicit drugs, medications or substances.
16. I agree that discussion about my treatment or changes in my pain medication regimen will take place only during my appointments, and not on the phone, be email, or by letter.
17. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
18. **It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribing by this physician or referral for further specialty assessment.**
19. **Renewals are contingent on keeping scheduled appointments. Refills will not be made after two consecutive missed appointments. To keep receiving refills, a pain medicine evaluation is required at least every month.** Please do not phone for refills after hours or on weekends. Refills will be made during scheduled office visits only if the visit coincides with the refill date, by patient pick up at the office, or via pharmacy faxed requests; all types of requests need to be called in **three business days prior to requiring a refill.**

20. It should be understood that any medical treatment is initially a trial, and that getting continued prescriptions is contingent on evidence of pain reduction and functional benefit.
21. (Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. My doctor may reduce or discontinue opioids if these side effects occur.
22. (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have birth defects while I am taking an opioid.
23. **I agree that this agreement is essential to my medical care, and my physicians' ability to treat my pain effectively, and that failure on the part of the Patient (myself) to comply with the terms of this agreement may result in the withdrawal of all prescribed medication by the physician/provider at Offices of Dr. Albert Lai, M.D., and the termination of the physician-patient relationship, with immediate discharge from the physician practice and Offices of Dr. Albert Lai, M.D.**
24. **I understand that if I am discharged from Offices of Albert Lai, M.D. and the care of the prescribing physician/provider due to non-compliance with this agreement, that I MAY be given a prescription for a 30 day tapering supply of my medication(s), so as to attempt to avoid withdrawal symptoms.**
25. This agreement will be reviewed and renewed while it is in effect.
26. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accept all of its terms.

_____

Physician Signature

_____

Patient Signature

_____

Patient Name (Printed)

_____

Date