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

☐ 23141 MOULTON PKWY
   SUITE 102
   LAGUNA HILLS, CA 92653

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

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 write you prescriptions for medications.

Thank you for your understanding and cooperation,

Management

Centers of Rehabilitation & Pain Medicine
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
PATIENT REGISTRATION

LAST NAME: __________________________________________
FIRST NAME: ___________________________ MIDDLE NAME : ____________________________
DATE OF BIRTH:____________________ SOCIAL SECURITY NUMBER:____________________________
SEX: M F DRIVERS LICENSE #:______________________________ STATE: ______
MARRITAL 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 #:________________________ ☐ MOBILE #:__________________________

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

EMAIL ADDRESS:___________________________________________________________

EMPLOYER:_________________________________OCCUPATION:__________________
WORK ADDRESS:___________________________________________________________

EMERGENCY CONTACT (OTHER THAN YOUR OWN NUMBER)
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

ALBERT LAI, M.D.
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

ALBERT LAI, M.D.
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 as to 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:__________________
### CRPM

**Patient Reschedule - Cancellation and Late Policy**

<table>
<thead>
<tr>
<th>Cancelling or Rescheduling</th>
<th>NEW Patients</th>
<th>ESTABLISHED Patients</th>
<th>LATE = Rescheduled</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>24 HRS</strong></td>
<td><strong>30 MIN</strong></td>
<td><strong>15 MIN</strong></td>
<td><strong>10 MIN</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>24 HRS NOTICE</strong></th>
<th><strong>30 MIN BEFORE</strong></th>
<th><strong>15 MIN BEFORE</strong></th>
<th><strong>10 MIN IS LATE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Should you need to reschedule or cancel.</td>
<td>Please arrive 30 minutes prior to your appointment.</td>
<td>Please arrive 15 minutes prior to your appointment.</td>
<td>Patients arriving 10 minutes or later will be rescheduled.</td>
</tr>
</tbody>
</table>

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

Patients arriving 15 minutes or more after will be considered as a “no-show” and will be rescheduled, in addition:

1st occurrence – Patient/parent will receive a letter advising of our policy.
2nd occurrence – 2nd letter + a **$50 No Show Fee** assessment.
3rd and subsequent occurrences – May potentially result in dismissal from practice + **an additional $50 No Show Fee**
Patient Reschedule / Late Arrivals / 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 later 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 no show fee assessment
- Third and subsequent occurrences – May potentially result in dismissal from practice and an 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:____________________________________
New Patient Questionnaire

Name: ____________________________________________________________

Age: ___________ Sex: ___________ Height: ___________ Weight: ___________

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.

Front  Back

Please Use the Key Below

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: _____
Other: ____________________________________________________________

How long can you:  Sit _______ minutes  Stand________minutes

**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: ___________________________

Facility: ___________________________ Phone: ___________________________ Image: ___________________________

Facility: ___________________________ Phone: ___________________________ Image: ___________________________

What Medical Treatment Have You Had?:

☐ Physical Therapy ________________  □ YES  □ NO  If YES, How many times? ____________

☐ Psychologist ________________  □ YES  □ NO  If YES, Name: ________________

☐ Spine Injection ________________  □ YES  □ NO  If YES, 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  If YES, Procedure: ________________

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 w/ 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:________________________
☐ Gallbladder  ☐ Other:________________________
☐ CABG  ☐ Other:________________________
☐ CA/Stent  ☐ Other:________________________

Family History:
Any family medical problems? ☐ YES  ☐ NO  If YES, Please explain?________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

13
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

If Yes, 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? ________________________________________________
_______________________________________________________________________________
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 absence, 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 your physician at the Offices of Albert Lai, M.D. can lead to a discharge and an inability to obtain narcotic prescriptions.**

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 and 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 brought 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, 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