Demographics

Full Name: *

First Name Last Name

Date of Birth: *

Month Day Year

Social Security Number:

Gender *

Male

Female

Mobile Phone Number: *

Home Number

Email: *

example@example.com

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Home Address: *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Emergency Contact Information

Martial Status

If Married: Name of Spouse

First Name

Last Name

If Married: Cell Phone Number of Spouse

Name of Emergency Contact

First Name

Last Name

Relationship to Patient:

Mobile Number

How did you hear about us? *

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Insurance Information

Primary Insurance Carrier Name:

ie. Horizon

Primary Care Physician (Name, Contact Information)

Pharmacy Information (Name, Address, Phone)

Claim/ID#:

Group #:

Policy Holder Name:

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First Name Last Name

Relationship to Patient:

Policy Card Holder Date of Birth:

Month Day Year

Employment Information

Occupation

Name of Employer

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Work Number

Accident Information

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Fill out this section if you are being evaluated related to a Motor Vehicle Accident or a Work Related Injury

Is this appointment related to an accident sustained in a vehicle or work? *

Are you currently working?

To what extent are you working?

Last Day Worked:

Month Day Year

Did your accident occur during work hours?

Type of Accident

Accident Date:

Month Day Year

State in which accident occurred?

Attorney Information

Please include attorney name, contact

Attorney Address

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Street Address

Street Address Line 2

Attorney's Phone Number

Attorney Fax Number:

Attorney Email:

example@example.com

Please provide a detailed description of your accident:

Name of Workers Compensation/Auto Injury Insurance Company

Claim or WCB#:

HISTORY OF PRESENT ILLNESS

Areas of pain & symptoms

Brief history of your symptoms *

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When did your symptoms begin? *

Month Day Year

Pain Scale *

	0	1	2	3	4	5	6	7	8	9	10	
No Pain												Severe Pain

Where on your body do you have discomfort?

	Left	Right	Both
Head			
Neck			
Mid-back			
Low back			
Shoulder			
Elbow			
Wrist			
Hand			
Chest			
Ribs			
Abdomen			
Pelvis			
Hip			
Knee			
Ankle			
Foot			

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Indicate Type of Discomfort:

	Yes	No
Sharp		
Stabbing		
Throbbing		
Dull		
Pressure		
Burning		
Stiffness		
Weakness		
Spasm		
Numbness/Tingling		

If other, please explain

Have you treated with other doctors for this problem?

Yes
No

If yes, where?

Please include name, number and address

Have you had any physical therapy for this problem?

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No

If yes, where?

Have you had any radiological studies performed (MRIs, CT Scans or X-Rays)?

Yes
No

If yes, please explain?

Include information what study was performed, which body part, date performed, and where it was performed

Past Medical/Surgical/Social History

Medical Problems - Please check all that apply *

No active or past medical history	Neck or Back Pain	Osteoarthritis
Osteoporosis	Neck or Back Disc Disease	Rheumatoid Arthritis
Psoriatic Arthritis	Spinal Fracture	Headaches/Migraines
Diabetes	High Blood Pressure	Heart Disease
Stroke/CVA	Hemiplegia	Blood Clots
Heart Failure	Chest Pain	Heart Attack (Myocardial Infarction)
Peripheral Vascular Disease	Thyroid Disease	Asthma
COPD	Pneumonia	Tuberculosis
COVID-19	Anemia	Bleeding Disorders
Cancer	Depression	Bipolar Disorder
Substance Abuse	Sleep Apnea	Restless Leg Syndrome
Chronic UTI	GERD	Irritable Bowel Syndrome
Lupus/SLE	Immune Disorder	Head Injury (TBI/Concussion/CTE)
Paralysis	Cerebral Palsy	Dementia
Alzheimer's Disease	Parkinson's Disease	Seizure Disorder

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- Diabetic Neuropathy
- Nerve Injury
- HIV/AIDs
- MRSA
- Hepatitis
- Fibromyalgia
- Kidney Disease
- Prior Gun Shot

Past surgeries and procedures - Please check all that apply *

- No prior surgeries or procedures
- Nerve Injections
- Joint Injections
- Facet Injections
- Epidural Injections
- Discectomy
- Spinal Fusion
- Kyphoplasty/Vertibroplasty
- Knee Replacement
- Knee Arthroscopy
- Shoulder Arthroscopy
- Hip Arthroscopy
- Hernia Repair
- Gallbladder Removal
- Implanted Defibrillator
- Cardiac Stent
- Heart Valve Implants
- Metal Implants
- Botox Injection
- Beauty/Aesthetic/Cosmetic Surgery

If other medical or surgical history, please include here

Are you on any blood thinners? *

If yes, please specify:

Medications (Please include supplements): *

Please include Name Dose and Frequency

Allergies *

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No Known Drug Allergies	IV dye/contrast	Iodine
Shellfish	Penicillin	Sulfa- drugs

Please explain what type of reaction you have? If other please explain

Social History

Do you drink Alcohol excessively?

Do you use Illicit Drugs?

Review of Symptoms

Please check any boxes of the symptoms you are experience both related to the chief complaint and unrelated

Review of Symptoms

Cramping	Spasm	Restricted Motion
Joint Swelling	Numbness	Tingling
Weakness	Fevers	Chills
Night Sweats	Weight Gain	Weight Loss
Fatigue	Headaches	Dizziness
Blurry Vision/Double Vision	Sensitivity to Light	Loss of Hearing
Ringing in the Ears	Ear Pain	Throat Pain
Cough	Shortness of Breath	Chest pain
Palpitations	Abdominal Pain	Nausea
Vomiting	Diarrhea	Constipation

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- Rectal bleeding
- Loss of Appetite
- Tremors
- Seizures
- Memory loss
- Loss of Consciousness
- Bowel/Bladder Incontinence
- Balance Problems - Trouble Walking
- Numbness in the Groin Region
- Trouble Sleeping at Right
- Depression
- Disorientation
- Mental Fog
- Rashes
- Wounds
- Skin Colour Changes
- Incontinence
- Pain during sex
- Blood in Urine
- Infections
- Redness of skin
- Skin Infection (Abscess/Boil/Cellulitis)
- Hives
- Seasonal allergies

If Yes, please explain:

Do you use Tobacco? *

If Yes, clarify which form of tobacco

Please enter your height (feet/inches)/weight(pounds)

Pregnant *

- Yes
- No

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Family History

Does anyone in your immediate family diagnosed with the following:

- Hypertension
- Diabetes
- Heart Disease
- Cancer
- Nerve or Muscle Disease
- Fibromyalgia
- Depression
- Bipolar Disorder
- Substance Abuse

If other please list or elaborate on the above.

Are you vaccinated for COVID? *

Do you use cannabis/marijuana

Diet

If you have a special diet or avoid certain foods please explain

Are you interested in Medical Weight Loss? *

I acknowledge receipt of, and have read, the following attached documents: *

- GENERAL CONSENT FOR CARE AND TREATMENT
- CONSENT TO USE AND DISCLOSE
- FINANCIAL DISCLOSURE FORM AND POLICY
- NOTICE OF PRIVACY PRACTICES
- PATIENT RIGHTS AND RESPONSIBILITY
- PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

MEDIA CONSENT FORM

ASSIGNMENT AND AUTHORIZATION TO

By signing below, I acknowledge that I have received and read this information prior to my visit.

PATIENT

PARENT OR LEGAL GUARDIAN

DATE *

Month Day Year

Hour Minutes

GENERAL CONSENT FOR CARE AND TREATMENT

1) To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. We shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.

2) To be informed of the services available at our office, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the office and any charges for services not covered by sources of third party payment.

3) To be informed if our office has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have the right to know the identity and function of these Institutions, and to refuse to allow their participation in the patient's treatment.

4) To receive from the patient's physician(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian along with the reason for not informing the patient directly shall be documented in the patient's medical record.

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5) To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record.

6) To be included in experimental research only when the patient gives informed, written consent to such participation. Or when a guardian gives such consent for an incompetent patient in accordance with the laws, rules and regulations. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices.

7) To voice grievances or recommend changes in policies and services to office personnel, the governing body, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal.

8) To be free from mental and physical abuse, and harassment, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient and others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of office personnel.

9) To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including but not limited to, auditory and visual privacy. The patient's privacy shall be respected when office personnel are discussing the patient.

10) To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the office without the patient's approval, unless another provider to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. We may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

11) To exercise civil and religious liberties, including the right to independent personnel decisions. No religious belief or practices, or any attendance at religious services, shall be imposed upon the patient.

12) To not be discriminated against because of age, race, religion, sex, nationality, or deprived of any constitutional, civil, and/or legal rights.

13) To expect and receive assessment, management, and treatment of pain as an integral component of that person's care.

14) To expect to exercise his/her rights without being subject to discrimination or reprisal

As a patient at the office, the patient has the following responsibilities:

1) Review and execute the Patient Responsibility For Follow-Up Care Pledge

2) Knowing your health care clinician's name and title.

3) Patients and families, as appropriate, must provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, and other matters relating to their health.

4) Telling us about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.

5) Provide office staff with correct and complete name, address, telephone and emergency contact information each time you see us so we can reach you in the event of a schedule change or to give medical instructions.

6) Patients and their families must report perceived risks in unexpected-changes in their condition or

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reactions to medications or treatment. They can help us understand their environment by providing feedback about service needs and expectations.

7) Patients and families, as appropriate, must ask questions when they do not understand their care, treatment, and service or what they are expected to do.

8) Patients and their families must follow the care, treatment, and service plan developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment and services. We make every effort to adapt the plan to specific needs and limitations of the patients. When such adaptations to the care, treatment and service plan are not recommended, patients and their families are informed of the consequences of the care, treatment, and service alternatives and not following the proposed course.

9) Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.

10) Patients and their families must follow the office's rules and regulations.

11) Patients and their families must be considerate of the office's staff and property, as well as other patients-and their property.

12) Patients and their families should promptly meet any financial obligation agreed to with the office.

If you have any questions regarding your rights and responsibilities, or, if you have any complaints or grievances on how these rights were or were not administered, you may speak to our office manager, who will initiate an investigation into your issue.

PATIENT

PARENT OR LEGAL GUARDIAN

WITNESS

DATE

Month Day Year

CONSENT TO USE AND DISCLOSE

By signing below, I, authorize **Sixth Borough Medical** and/or its agents and attorneys to obtain medical information

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regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to Sixth Borough Medical about me, including medical records, X-ray reports, narrative reports, and any other report or information regarding my physical condition and/or its agents and attorneys to obtain medical information regarding

PATIENT

PARENT OR LEGAL GUARDIAN

WITNESS

DATE

Month Day Year

FINANCIAL DISCLOSURE FORM AND POLICY

Our Financial Disclosure Form and Policy is designed to address the needs and concerns of our patients, and to prevent patients from being surprised with any bills that they may receive from our office. Please read this Policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate with many insurance companies, including Medicare, and it is your responsibility to ensure that we participate with your specific plan. Payments for all services rendered are ultimately the patient's responsibility. In order for us to bill your insurance company, patients must provide proof of insurance at each visit. If the patient does not have his or her insurance card, or if coverage cannot be verified, the patient will be responsible for payment in full at the time of the visit. We make every attempt to accurately confirm our participation in various plans, but it is ultimately the patient's responsibility to know their insurance coverage and benefits. We strongly recommend calling your insurance company prior to your visit to verify coverage. Rejection of all or part of your medical insurance claim by your insurance company does not relieve you of your financial obligation. All patients, new and returning, are required to present their current insurance card(s) at every visit as well as a photo ID.

Co-Payments: Co-payments (a fixed dollar amount that is assigned to the patient) are due at the time of each visit. They cannot be waived.

Co-Insurance and Deductibles: You will be billed for co-insurance (a percentage of total charges that are assigned to the patient) after your claim is processed by your insurance company. You will also be billed for any amounts applied to your deductible. These fees cannot be waived.

Out-Of-Network: If we do not participate with your insurance company, or your insurance plan does not cover the services that the office will provide you, then the services we provide you will be considered out-of-network. You will,

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Other Non-Covered Services: In some cases, your insurance company may consider the services we provide as not being medically necessary, such as cosmetic procedures. Again, we strongly recommend that you call your insurance company prior to your visit to verify coverage. If the services are not covered, you must pay for these services in full at the time of each visit. Payment for cosmetic procedures is due in full at the time of service.

Self-Pay Patients: Payment is due in full at the time of service for self-pay patients.

Methods of Payment: We accept cash, checks and all major credit cards. Payments may be made in person, by mail or over the phone.

Outstanding Balances: Outstanding balances may result from remaining patient balances after insurance has been billed. For instance, unmet deductibles, additional co-payments, non-covered services or any other charge the insurance company may assign to the patient will be the patient's responsibility. We require all patients to provide a credit card on file at the time of each visit. Your account will be considered past due if any balances are outstanding after 90 days. Outstanding balances will then be charged to the credit card on file after notification to the patient 30 days in advance of the charge. Individual automatic charges will be limited to $1000 and annual automatic charges will be limited to $1000. We will request to update your credit card information on an annual basis.

Attorneys' Fees and Costs: In the event that your account is placed with an attorney or collection agency to collect any unpaid balance remaining on your account, you will pay interest of 1.5% per month of the outstanding balance to be calculated starting from the last date of service. In addition, you agree to pay for any attorneys' fees and costs if we place your account with an attorney or collection agency to collect any outstanding balance remaining on your account. If you dispute the outstanding balance, and we have to engage an attorney to defend the dispute, then you shall be responsible for all attorney's fees and costs incurred by us in defending against the dispute.

Credits and Refunds: Any refunds owed to your insurance company will be returned to the insurance company by check. Any credits or refunds owed to a patient will first be used to pay any outstanding balance. Remaining patient credits and refunds can be left on the account to be used towards future charges or can be returned to the patient (or responsible party who made payment) by check or applied back to the credit card used to make payment. Please allow 30 days for processing check and credit card transactions.

Cancellations, Rescheduled Appointments and No-Shows: We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. We have a 72-hour cancellation policy. Since we understand that illness and other problems may be beyond the control of the patient, we will not charge you for the first missed or canceled appointment. Subsequent missed appointments ("no shows"), same-day cancellations and same-day rescheduled appointments are subject to a $75 cancellation fee. These fees are applied whether or not you receive a reminder call, text or email from our office. They also apply to appointments made just one day in advance.

Responsible Party: When a patient is less than 18 years of age, the parent or guardian who signs this Policy is responsible for all fees incurred by the minor. As a result, it is the parent or guardian who would be sent to collections if an account is past due. When a patient turns 18 or older, he or she becomes responsible for any outstanding balance not covered by insurance, regardless of who is the insurance policyholder subscriber. If a parent or guardian wants to assume complete financial responsibility for an adult child, then the parent or guardian must sign below along with the adult child.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes.

Referrals: If we refer you to a provider outside of our offices, to the extent the information is available, we will provide you with the name, practice name, mailing address, and telephone number of that provider so that you can determine whether that provider participates with your insurance company. We strongly recommend that you contact your insurance company for further consultation on costs associated with the services provided by these other providers.

By signing below, you acknowledge the following: (1) You have read this Policy; (2) The office has identified to you in writing and/or its website home page the insurance companies that it has an in-network contract with, and also provided

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this information at the time of your appointment; (3) If the office is out-of-network with your insurance company, the office provided an estimated amount that you will be charged for the services that the office provides you; (4) If the office referred you to a different provider, the office provided you with the above mentioned information so that you may contact the provider to determine if he or she participates in your insurance; (5) You were given an opportunity to ask questions regarding this policy and your questions, if any, have been answered; and (6) You authorize Sixth Borough Medical to release all information necessary regarding the services rendered to you including to you insurance company to secure payment

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

Pursuant to the Privacy Rules established by the Health Insurance Portability and Accountability Act of 1996, and the underlying regulations at 45 C.F.R. Parts 160 and 164, we are legally required to protect the privacy of your health Information. We call this information “protected health information” or “PHI” for short. It includes information that can be used to identify you and that we’ve created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about your privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the Reception Area. You can also request a copy of this notice from our office at any time.

For more information regarding your rights, please see the information provided at: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

II. HOW MAY WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health Information for many different reasons. The privacy rules require that we get your specific authorization for some of these uses or disclosures. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

According to the Privacy Rules, we may use and disclose your PHI without your authorization for the following reasons:

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or a laboratory to order a blood test.

2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our

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example, we may disclose your demographic information to anesthesia care providers for payment of their services.

3. For health care operation. We may disclose your PHI as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultations, and other in order to make sure we're complying with the laws that affect us.

4. When disclosure is required by federal, state or local law judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law required that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence: when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. To coroners, funeral directors, and for organ donations. We may disclose PHI to organ procurement organization to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

9. To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. Uses and Disclosures Where You Have the Opportunity to Object:

1. Disclosure to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment of your health care, unless you object in whole or in part.

2. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

C. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use of disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons involved in your care would be permitted.

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D. Uses and Disclosures That Require Your Authorization

The following use and disclosures of your health information will only be made pursuant to us receiving a written authorization from you:

Most uses and disclosure of psychotherapy notes (except as permitted or required under the HIPAA Rules).

Uses and disclosure of your health information for marketing purposes, unless the marking is either: (a) a face-to-face communication made by us to you; or (b) a promotional gift of nominal value provided by us; or as otherwise may be permitted by the HIPAA Rules.

Disclosures that constitute a sale of your health information, except as permitted under the HIPAA Rules.

Other uses and disclosures not permitted or required as set forth in this Notice or as required under the HIPAA Rules or applicable federal or state law.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following right with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternative address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. If we do we will tell you, in writing, our reason for the denial and explain your right to have the denial.

If you request a copy of your information, we may charge you a reasonable fee for the cost of copying, mailing or other costs incurred by us in complying with your request or as required by law. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing or as required by law. We may deny or request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and

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your right to file a written statement of disagreement with the denial, if you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice.

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with a person listed in Section V below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, DC 20201, 1-877-696-6775. We will take no retaliatory action against you if you file a complaint about our privacy practices. You can also go to the following website: www.hhs.gov/ocr/privacy/hipaa/complaints/

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the office.

VI. EFFECTIVE DATE OF THIS NOTICE

This notice is effective January 1, 2020

PATIENT RIGHTS AND RESPONSIBILITIES

1) To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. We shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility.

2) To be informed of the services available at our office, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the office and any charges for services not covered by sources of third party payment.

3) To be informed if our office has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have the right to know the identity and function of these Institutions, and to refuse to allow their participation in the patient's treatment.

4) To receive from the patient's physician(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected results. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian along with the reason for not informing the patient directly shall be documented in the patient's medical record.

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5) To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record.

6) To be included in experimental research only when the patient gives informed, written consent to such participation. Or when a guardian gives such consent for an incompetent patient in accordance with the laws, rules and regulations. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices.

7) To voice grievances or recommend changes in policies and services to office personnel, the governing body, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination or reprisal.

8) To be free from mental and physical abuse, and harassment, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient and others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of office personnel.

9) To be treated with courtesy, consideration, respect and recognition of the patient's dignity, individuality, and right to privacy, including but not limited to, auditory and visual privacy. The patient's privacy shall be respected when office personnel are discussing the patient.

10) To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the office without the patient's approval, unless another provider to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. We may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

11) To exercise civil and religious liberties, including the right to independent personnel decisions. No religious belief or practices, or any attendance at religious services, shall be imposed upon the patient.

12) To not be discriminated against because of age, race, religion, sex, nationality, or deprived of any constitutional, civil, and/or legal rights.

13) To expect and receive assessment, management, and treatment of pain as an integral component of that person's care.

14) To expect to exercise his/her rights without being subject to discrimination or reprisal

As a patient at the office, the patient has the following responsibilities:

1) Review and execute the Patient Responsibility For Follow-Up Care Pledge

2) Knowing your health care clinician's name and title.

3) Patients and families, as appropriate, must provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, and other matters relating to their health.

4) Telling us about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.

5) Provide office staff with correct and complete name, address, telephone and emergency contact information each time you see us so we can reach you in the event of a schedule change or to give medical instructions.

6) Patients and their families must report perceived risks in unexpected-changes in their condition or

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reactions to medications or treatment. They can help us understand their environment by providing feedback about service needs and expectations.
7) Patients and families, as appropriate, must ask questions when they do not understand their care, treatment, and service or what they are expected to do.

8) Patients and their families must follow the care, treatment, and service plan developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment and services. We make every effort to adapt the plan to specific needs and limitations of the patients. When such adaptations to the care, treatment and service plan are not recommended, patients and their families are informed of the consequences of the care, treatment, and service alternatives and not following the proposed course.

9) Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.

10) Patients and their families must follow the office's rules and regulations.

11) Patients and their families must be considerate of the office's staff and property, as well as other patients-and their property.

12) Patients and their families should promptly meet any financial obligation agreed to with the office.

If you have any questions regarding your rights and responsibilities, or, if you have any complaints or grievances on how these rights were or were not administered, you may speak to our office manager, who will initiate an investigation into your issue.

Patient/Parent/Legal Guardian

Date

Month Day Year

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by physicians and other providers are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician or provider in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my physician or provider.

I understand that if a provider in this office refers me to see another physician or provider or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these

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I understand that it is solely my responsibility to follow any of the medical advice given by any provider in this office and any bad health outcome from my failure to follow the advice of my physician or any other provider in this office should be expected.

PATIENT/PARENT/LEGAL GUARDIAN

DATE

Month Day Year

AUTHORIZATION TO RELEASE MEDICAL RECORDS

1) I, authorize SIXTH BOROUGH MEDICAL to release and disclose my medical records identified, to the following persons:

NAME OF INDIVIDUAL OR ENTITY *

RELATIONSHIP TO PATIENT

2) a. I, authorize the release of my complete medical records on file with SIXTH BOROUGH MEDICAL to the above named individual or entity including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse. *

2) b. I authorize the release of my complete medical records on file with Sixth Borough Medical to the above named individual or entity with the exception of the following information (check all that apply)

- Mental Health Records
- Communicable diseases
- Alcohol/drug abuse treatment

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3) I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

4) I understand that the individual or entity receiving my medical records pursuant to this authorization may use or disclose the records to third parties.

5) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

PATIENT/PARENT/LEGAL GUARDIAN

MEDIA CONSENT

I agree and consent for SIXTH BOROUGH MEDICAL and any of their designees to take videotapes or photographs of me or my child (or person for whom I am legal guardian) pre-procedure, during the procedure, or post-procedure. I understand that the videotapes or photographs along with my age (or my child's age), description of prosthesis and technique used with the procedure may be used for (1) your medical purposes such as explaining observations, goals and limitations; (2) teaching purposes such as medical teaching for other providers and/or medical students, including in a classroom or conference room setting, and/or for publication in medical textbooks or journals; (3) for educational and consultation purposes with other patients; and/or (4) social media purposes including office Internet website optimization, social media advertising, Internet based advertising, printed media, promotional and/or testimonial purposes. With the exception of (1), the videotapes or photographs for 2, 3 and 4 will not be included in the medical records.

I understand that the videotapes and/or photographs for (2), (3) and (4) above may be seen by members of the general public. Although the videotapes and/or photographs will be used without identifying information such as name and address, I understand that it is possible that someone may recognize me (or my child).

I understand that the videotapes and/or photographs are the sole property of SIXTH BOROUGH MEDICAL. SIXTH BOROUGH MEDICAL will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for any requested use or disclosure pursuant to this Media Consent Form.

I, on behalf of myself and my assigns and representatives, release and discharge SIXTH BOROUGH MEDICAL and their respective representatives, employees and all parties acting under this consent, license and authority from all rights that I may have in the videotapes and/or photographs and from any claims, actions, damages, losses of any kind, rights of any kind, and expenses (including without limitation attorneys' fees and costs) that I may have relating to the use of the videotapes and/or photographs consistent with this consent including any claim for payment in connection with distribution or publication of the photographs.

I agree not to mention, write, publicize, print or use the name SIXTH BOROUGH MEDICAL including, but not limited to, in any social media, internet website, or printed media without the express written consent of SIXTH BOROUGH MEDICAL.

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I agree that SIXTH BOROUGH MEDICAL may send my videotapes and/or photographs via unencrypted email. I understand that there are risks of protected health information, including videotapes or photographs, being sent via unencrypted email, including but not limited to the email being sent to the wrong person and the email being captured electronically en-route. I have been informed of these risks, understand the risks and agree that SIXTH BOROUGH MEDICAL may use unencrypted email.

I have been given an opportunity to read this consent and ask questions. I understand that I have the right to revoke this authorization at any time by sending a written notification of my revocation to SIXTH BOROUGH MEDICAL. However, I also understand that once videotapes and/or photographs are published, they will remain in the public domain and any withdrawal of my consent will have no effect on the videos and photographs already used or disclosed.

I understand I have the right to:

1. Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
2. Refuse to sign this authorization
3. Receive a signed copy of this authorization.

I agree to allow videotapes and photographs to be taken and used for the following purposes:

your medical purposes such as explaining observations, goals and limitations;

teaching purposes such as medical teaching for other surgeons and/or medical students, including in a classroom or conference room setting, and/or for publication in medical textbooks or journals;

for educational and consultation purposes with other patients;

social media purposes including office Internet website optimization, social media advertising, Internet based advertising, printed media, promotional and/or testimonial purposes.

PATIENT/PARENT/LEGAL GUARDIAN

EMAIL AND TEXTING POLICY

By emailing or texting SIXTH BOROUGH MEDICAL or any of its providers or staff, you are accepting the inherent privacy limitations of online communication. Most standard email providers such as Gmail, Yahoo, Hotmail, etc. and most cellular providers do not provide a secured or encrypted means of communication. As a result, there is risk that any protected health information contained in an email or text message may be disclosed to, or intercepted by, unauthorized third parties. Additionally, email and text messages accessible through personal computers, laptops, or phones have inherent privacy risks especially when the email or cellular account is provided by an employer, when the account is not password protected, or the account is shared.

When consenting to the use of email or text through such unsecured or unencrypted systems, you are accepting responsibility for any unauthorized access or disclosure to protected health information contained within the message. SIXTH BOROUGH MEDICAL will not be responsible for unauthorized access of protected health information while in transmission and will not be responsible for safeguarding information once it is delivered.

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In addition, emails and text messages cannot replace communications between you and your provider. There is no guarantee that SIXTH BOROUGH MEDICAL or its providers and staff will be actively monitoring emails and text messages, so responses and replies sent to or received by you may be hours or days apart. Email and text messages may be inadvertently missed or errors in transmissions may occur. SIXTH BOROUGH MEDICAL will not be responsible for any issues caused by delays or errors in communications. Importantly, if you have an immediate emergency situation, you must dial 9-1-1 if applicable.

At SIXTH BOROUGH MEDICAL's discretion, any email or text message received or sent may become part of your medical record.

PLEASE SELECT ONE OF THE FOLLOWING

- SIXTH BOROUGH MEDICAL and its providers and staff may communicate with me via email and text messaging
- SIXTH BOROUGH MEDICAL and its providers and staff may communicate with me via email and text messaging but only in connection with scheduling appointments
- SIXTH BOROUGH MEDICAL and its providers and staff should NOT communicate with me via email and text messaging

PATIENT/ PARENT/LEGAL GUARDIAN

DATE

Month Day Year

ASSIGNMENT AND AUTHORIZATION TO APPEAL FORM

Assignment of Benefits and Claims

I hereby assign and transfer to SIXTH BOROUGH MEDICAL all benefits payable by my insurance company for services performed by SIXTH BOROUGH MEDICAL.

I hereby authorize SIXTH BOROUGH MEDICAL to submit a claim to my insurance company or intermediary for all services rendered by SIXTH BOROUGH MEDICAL and to exercise any appeals and other rights under my policy on my behalf.

I direct my insurance company, or its intermediaries, to issue a payment check directly to SIXTH BOROUGH MEDICAL.

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If my insurance company will not directly pay SIXTH BOROUGH MEDICAL, I authorize and direct the insurance company to send all checks and copies of Explanation of Benefit forms in connection with the services of SIXTH BOROUGH MEDICAL to SIXTH BOROUGH MEDICAL as my agent for delivery of said items and use.

Limited Power of Attorney

In the event my insurance company responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited/special power of attorney and appoint and authorize SIXTH BOROUGH MEDICAL as my agent and attorney to collect payment for medical services rendered by SIXTH BOROUGH MEDICAL directly from the insurance company in this case, including filing an arbitration demand or lawsuit. I specifically authorize SIXTH BOROUGH MEDICAL to utilize its agents and attorneys to institute any required proceedings against that insurance company in my name or in SIXTH BOROUGH MEDICAL s name as a medical provider rendering services to me. I further grant a limited power of attorney to SIXTH BOROUGH MEDICAL as my medical provider to receive and collect directly from the insurance company money due SIXTH BOROUGH MEDICAL for services rendered to me in this matter, and hereby instruct the insurance company to pay SIXTH BOROUGH MEDICAL directly any monies due you for medical services rendered to me.

Patient Receipt of Checks

In the event that I receive direct payment of any amounts due to SIXTH BOROUGH MEDICAL, I agree to forward immediately to SIXTH BOROUGH MEDICAL any checks made payable to me for services rendered by SIXTH BOROUGH MEDICAL and any Explanation of Benefits (EOB) to the extent not sent directly to SIXTH BOROUGH MEDICAL. I agree to notify SIXTH BOROUGH MEDICAL upon receipt of such check and to endorse the check “Pay to the Order of SIXTH BOROUGH MEDICAL”, and immediately mail the check and EOB to SIXTH BOROUGH MEDICAL keeping copies of the check and EOB for my records.

DATE

Month Day Year

PATIENT/ PARENT/LEGAL GUARDIAN

New Jersey Department of Banking and Insurance

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CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.1 This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you. There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage. At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports. You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, agree to: representation in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care

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Appeals Program, and independent contractors reviewing the appeal.   My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner. release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Ins. ID#:

I am the Personal Representative (provide contact information on back)

1 If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to: New Jersey Department of Banking and Insurance Consumer Protection Services Office of Managed Care – Attn: IHCAP P.O. Box 329 Trenton, NJ 08625-0329 OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807 You may also want to send a copy of your notice of revocation to the health care provider.

Telemedicine Consent

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TELEMEDICINE PATIENT CONSENT

PURPOSE: The purpose of "Telemedicine Consent Form" is to get the patient's consent in order to participate in appointments of telemedicine cares.

RECORDS: Telecommunications with patients will not be recorded and stored. Patients' medical information obtained by the diagnosis and analysis can be used anonymously for further improvements in scientific studies.

TELEMEDICINE INFORMATION: The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with video and audio.

ACCESS: The patient accepts that he/she needs access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telemedicine appointment.

PATIENT RIGHTS: The patient can withdraw his/her consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

By signing this form,

I understand that all the laws that are protecting my privacy of medical history or information are also applied to telemedicine practices.

I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures.

I understand that I can be charged the additional fees that my insurance does not cover.

I accept that I authorize health care professionals and use telemedicine for my treatment and diagnosis.

Date *

Month Day Year

Pain Treatment with Medication: Treatment

Patient Agreement

This Agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances for pain. I have been told about the side effects that I may experience. My prescriber is undertaking to treat me with controlled substances for pain because:

I, understand and voluntarily agree to the following

1. I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment, I will communicate fully with my prescriber

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2. I will take my medication as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during my course of treatment.

3. I will not attempt to obtain pain medications from any other prescribers and understand that my prescriptions will be issued only during scheduled office visits with the treatment team or during regular office hours. If I require
surgery or emergency treatment, and I am able to communicate, I will tell the health care professional taking care of me about all the medications I am taking and, at or before my next refill, I will tell my prescriber about my use of
medications in these circumstances.

4. I agree not to use illegal drugs or alcohol while on these medications.

5. I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness, or sedation.

6. I will use one pharmacy to get all my medications:

7. I understand that I may be referred to other health care professionals for other modes of treatment, such as physical therapy, exercise, relaxation techniques or psychological counseling, or for certain diagnostic tests and that my prescriber may speak with other health care professionals about my treatment plan.

8. I will keep the medicine safe, secure, and out of reach of others, and will dispose of unused medications in a Project Medicine Drop Box, through a Take-back Program or in a drug disposal pouch.

9. I will not sell this medicine or share it with others. If my medicine or prescription is lost or stolen, I understand that it may not be replaced.

10. I understand that I may need to submit to random urine drug testing and pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and
only one pharmacy by checking the Prescription Monitoring Program web site.

11. I understand that I may need to submit pharmacokinetic genetic testing if requested by my prescriber.

12. I understand that I may be required to have a psychological/psychiatric evaluation. During the duration of my medication treatment, I may have to continue psychological treatment in conjunction with pain treatment

13. I understand that I may be prescribed Narcan (naloxone) and that I need to show proof that I obtained before any medication treatment commences.

14. I understand that if I do not follow all of the terms of this Agreement, my prescriber may stop prescribing pain medications, and/or that I could be required to find another prescriber or health care professional for my future medical treatment.

By signing this form, I declare that I understand the points state above (1-14) and agree.

Date *

Month Day Year

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