GORMAN MEDICAL, P.C.

8540 Scarborough Dr, Suite 370
Colorado Springs, Co 80920
Phone: 719-358-8270 Fax: 719-358-8299

NEW PATIENT REGISTRATION

Patient Printed Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: Male ☐ Female ☐ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell/Text: _____ Message: _____

May we leave a message: Yes ☐ No ☐ Email: _____ Marital Status: _____

Employer: _____ Occupation: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____ Work: _____

How did you hear about us: Family/Friend ☐ Internet ☐ Ad in Newspaper ☐ Physician Referral (If checked, see below) ☐

Physician Name: _____ Phone: _____

Previous Primary Care Facility: _____

Previous Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: _____

Identification Number: _____ Group Number: _____ Co-pay: s_____

Please fill in the following information if the subscriber is NOT the patient:

Subscriber DOB: _____/_____/_____ Subscriber SSN: _____

SECONDARY INSURANCE: _____

Identification Number: _____ Group Number: _____ Co-pay: s_____

Please fill in the following information if the subscriber is NOT the patient:

Subscriber DOB: _____/_____/_____ Subscriber SSN: _____

Signature of Patient or Authorized Individual: I authorize release of medical or other information necessary to process all Government and/or commercial insurances. I authorize the payment of medical benefits to the attending physician or supplier for services rendered. I understand that I am financially responsible for all charges not paid by my insurance and/or worker's compensation carrier.

Patient Signature: _____ Date: _____

SOCIAL HISTORY

Ever smoke? Yes ☐ No ☐ Currently smoking? Yes ☐ No ☐ Packs per day/week: ___ How many years: ___

Current smokers, are you ready to quit? Yes ☐ No ☐ **Former** smokers, what was your quit date? _____

Drink alcohol? Yes ☐ No ☐ Per day: _____ Per week: _____ How many years: _____

Recreational Drug use? Yes ☐ No ☐ If yes, Explain: _____

_____

Have you been or currently being sexually abused, threatened, or hurt by anyone? Yes ☐ No ☐

PERSONAL HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO
ASTHMA		
PNEUMONIA/LUNG DISEASE		
TUBERCULOSIS		
HEART ATTACK/PROBLEMS		
HIGH BLOOD PRESSURE		
STROKE		
BLOOD CLOTS IN LUNGS OR LEGS		
KIDNEY INFECTIONS/STONES		
SEXUALLY TRANSMITTED DISEASE		
HIV/AIDS		
THYROID DISEASE		
DIABETES		
EATING DISORDERS		
DEPRESSION/ANXIETY		
ARTHRITIS/JOINT PAIN/BACK PROBLEMS		
COLLAGEN VASCULAR DISEASE (LUPUS)		
CANCER		
REFLUX/HIATAL HERNIA/ULCERS		
HEPATITIS/JAUNDICE/LIVER DISEASE		
GALLBLADDER DISEASE		
COLITIS/CROHN'S DISEASE		
ANEMIA		
BLOOD TRANSFUSIONS		
MIGRAINE HEADACHES		
SEIZURES/CONVULSIONS/EPILEPSY		
OTHER		

INJURIES/ILLNESSES

CHECK HERE IF NONE- ☐

REASON	DATE OR YEAR	HOSPITAL

OPERATIONS/HOSPITALIZATIONS

CHECK HERE IF NONE- ☐

SURGERY/REASON	DATE OR YEAR	HOSPITAL

CURRENT MEDICATIONS

CHECK HERE IF NONE - ☐

(INCLUDING HORMONES, VITAMINS, HERBS, NON-PRESCRIPTION MEDICATION)

CURRENT MEDICATIONS	DOSAGE (mg) & TIMES PER DAY	DATE OF LAST FILL	PRESCRIBER

MEDICATION ALLERGIES OR OTHER ALLERGIES

CHECK HERE IF NONE- ☐

ALLERGY	TYPE OF REACTION

OBSTETRIC HISTORY

(FEMALES ONLY)

CHECK HERE IF NO PREGNANCIES- ☐

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS		LIVE BIRTHS		LIVING CHILDREN	

#	BIRTH DATE	BIRTH WEIGHT	SEX	WEEKS PREGNANT	TYPE OF DELIVERY	COMPLICATIONS
1.						
2.						
3.						
4.						

GYNECLOGIC HISTORY

DATE OF LAST MENSTRUAL PERIOD (FIRST DAY)		
AGE MENSTRUAL PERIODS BEGAN		
HOW OFTEN DO YOU GET YOUR MENSTRUAL PERIOD		
LENGHTH OF YOUR MENSTRUAL PERIOD (NUMBER OF DAYS BLEEDING)		
	YES	NO
ANY RECENT CHANGES IN YOUR PERIODS?		
ARE YOUR MENSTRUAL PERIODS HEAVY?		
DO YOU BLEED BETWEEN MENSTRUAL PERIODS?		
DO YOU BLEED AFTER INTERCOURSE?		
DO YOU HAVE PAINFUL MENSTRUAL PERIODS?		
HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE (STD)		
HAVE YOU HAD PELVIC INFLAMMATORY DESEASE (PID)		
DATE OF LAST PAP TEST:		
WAS IT NORMAL?		
HAVE YOU EVER HAD AN ABNORMAL PAP TEST		
DO YOU HAVE PELVIC PAIN?		
DO YOU HAVE ENDOMETRIOSIS?		
DO YOU HAVE FIBROIDS?		
DO HAVE PAIN WITH INTERCOURSE?		
CURRENT METHOD(S) OF BIRTH CONTROL: ☐ BIRTH CONTROL PILLS ☐ DEPO PROVERA ☐IUD ☐NUVARING ☐TUBAL LIGATION ☐VASECTOMY ☐CONDOMS ☐ OTHER: _____		

REVIEW OF SYSTEMS

PLEASE MARK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU NOW OR SINCE ADULTHOOD. IF YOU ARE NOT SURE, PLEASE PUT A (?) NEXT TO THE SYMTOM

	NO	NOW	PAST	NOTES
CONSTITUTIONAL				
FEVER	☐	☐	☐	
EYES				
DOUBLE VISION	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
EAR, NOSE AND THROAT				
MOUTH SORES	☐	☐	☐	
HEARING LOSS	☐	☐	☐	
STREP THROAT	☐	☐	☐	
CARDIOVASCULAR				
CHEST PAIN	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
RESPIRATORY				
WHEEZING/ASTHMA	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLINTARY LOSS OF GAS OR STOOL	☐	☐	☐	
GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	
MUSCLE PAIN/JOINT PAIN	☐	☐	☐	

SKIN				
RASH	☐	☐	☐	
SORES	☐	☐	☐	
MOLES	☐	☐	☐	
ACNE	☐	☐	☐	
	NO	NOW	PAST	NOTES
BREASTS				
LUMPS	☐	☐	☐	
NIPPLE DISCHARGE	☐	☐	☐	
NEUROLOGIC				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	
WOULD YOU LIKE A REFERRAL TO A COUNSELOR? ☐ YES ☐ NO				
ENDOCRINE				
DRAMATIC WEIGHT CHANGE	☐	☐	☐	
EXCESS HAIR GROWTH OR LOSS	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
DES EXPOSURE	☐	☐	☐	
DIABETES	☐	☐	☐	
HEAT OR COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS THAT DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
OTHER				
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

FAMILY HISTORY

RELATION	LIVING	DECEASED	AGE	CAUSE
MOTHER				
FATHER				
SIBLINGS				
CHILDREN				

ILLNESS	YES	WHICH RELATIVE(S)	AGE OF ONSET
DIABETES			
STROKE			
BLOOD CLOTS IN LUNGS OR LEGS			
HEART DISEASE			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
RECURRENT MISCARRIAGE			
INFERTILITY			
BIRTH DEFECTS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
OTHER			

RADIOLOGY POLICY

To ensure you receive the best possible care here at Gorman Medical, **all** imaging/radiology orders sent by our providers, will be sent to **(CSI) Colorado Springs Imaging Center**. CSI is an independent, locally owned diagnostic center that our practice prefers to work directly with due to their facility providing us with accurate results in a prompt, timely manner. If for any reason, you are unable to establish care with CSI, please discuss this matter with the provider. Imaging performed at any other facility is your (the patient's) responsibility to obtain the results and provide them to your provider.

Patient Signature: _____ Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

Providers:
Charles H. Ripp, MD
Fran J. Gorman, ANP-C
Tina Gehrke, FNP-C
Elise Musolf, DC, FNP-C

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends, and other relations regarding medical treatment. Each person must be listed individually by name, relation and phone number.

By signing this consent, you are authorizing the permission to leave information concerning your health in both emergent and non-emergent situations.

Times our office may contact below person(s):

-As a reminder that you have an appointment.
-After you had a procedure to follow up.
-For questions regarding the payment of your care.
-For any test results.

Please print name and relationship for each person to whom you are authorizing release of private healthcare/medical information. Gorman Medical, P.C. endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. **If you are not wanting to name anyone, please leave the slots blank and then print and sign below.**

_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation

Patient Printed Name: _____ Date: _____

Patient Signature: _____

To review HIPAA rights, visit: www.hhs.gov/ocr/privacy/hipaa/understanding

FINANCIAL POLICY

Welcome to Gorman Medical! We are pleased that you have chosen us to provide your care and services. We would like to inform you of our payment policies. We accept cash and credit cards for payment (**no personal checks**).

No Insurance/Non-Contracted Insurance: If you have no insurance, we expect you to pay for your visit at the time of service. Non-contracted insurance will be billed if appropriate insurance information is given, however, payment will be expected at the time of service. *$150 for new patients and $75 for established patients*.

Medicare: We are a participating provider for the Medicare program. We will submit your claim/ services to Medicare. If you have a secondary or supplemental, we will submit after payment from Medicare, however, we must have a copy of your card and the appropriate information.

Medicaid and Medicaid HMO: We do participate with the Medicaid program. You must provide us with a copy of your Medicaid card indicating that you are eligible for Medicaid at the time of service. Should services be rendered, and you are no longer eligible for Medicaid coverage, you will be responsible for payment based on our normal fee schedule.

All co-pays are to be paid on the day of the service to include a $2 office copay and $1 lab copay.

Contracted Insurance (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, the address to submit clams to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service and any amounts not covered by your insurance, including the deductible. If your coverage is denied for any reason you are responsible for payment of the entire balance due, based on our normal fee schedule.

Worker's Compensation: We do not accept Worker's Compensation insurance. You will need to find another provider.

Auto Accidents: We do not accept Auto Accident insurance. You will need to find another provider.

Ancillary Services: We try to arrange for labs, radiology and any other testing to be provided at a facility which participates with your insurance. However, with the constantly changing insurance contracts and plans we are not always aware of any changes made to these participation lists. As the patient, please notify us of any concerns as it is your insurance and your responsibility to know what facilities your insurance participates with to lower your costs.

Referrals and Authorizations: We attempt to assist with referrals and authorizations; however it is ultimately your responsibility to obtain any referrals or authorizations for visits, procedures, testing or any other service provided or ordered by Gorman Medical providers. Should your insurance deny payment for no referral, no authorization, or not medically necessary you will be deemed financially responsible for all services rendered at Gorman Medical PC.

No Show Fees and Missed Appointments: When we schedule your appointment, this is your time that has been reserved with the doctor. We cannot fill that space if you do not notify us in advance of your inability to make the appointment. Please note that **reminder calls are strictly a courtesy**. Ultimately you are responsible for all appointments made. To avoid any fees, we request a 24-hour notice. We do accept a late cancel within the 24hr time frame before or after the appointment time. Fees do depend on the type of appointment that was missed:

Appointment Type	Late Cancel Fee	No Show Fee
Follow Ups	$25.00	$50.00
Script Pick Ups	$0	$25.00
Injection Procedures	$75.00	$150.00
EMG Procedures	$35.00	$85.00

These fees will not be billed to your insurance and you are responsible to pay within 30 days of the missed appointment. Frequent attendance violations can lead to a dismissal from practice.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby assign my Medicare and/or any other insurance benefits to which I am entitled. I authorize and direct my insurance carriers(s) including private insurance, and other health /medical plan to issue payment check(s) directly to Gorman Medical PC for services rendered to me or my dependents regardless of my insurance benefits, if any.

I authorize Gorman Medical, P.C. to furnish and/or release any information necessary to insurance carriers concerning my illness or treatment to process my insurance claims. A photocopy of my signature can be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked in writing.
I have requested medical services from Gorman Medical PC on behalf of my dependents or myself and I understand that by making this request I become fully responsible for all charges incurred during authorized treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I will be responsible not only for the charges incurred but also any costs involved in collection of my account. These include but are not to be limited to interest charges, re-billing fees, court costs, attorney fees, and collection costs. In the event my account becomes delinquent and turned to collection agency or attorney due to non-payment, that I will pay an additional 33.3 % of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collections) plus any court costs and attorney's fees incurred relating to the collection account.
Insurance coverage is a matter between my insurance company and myself; **I am ultimately responsible for the payment of my account.**

I have had the opportunity to read and understand the payment policies set forth and have been given the opportunity to ask questions about these policies. I understand my responsibility for payment to Gorman Medical PC and/or providers representing Gorman Medical, P.C.

*****IMPORTANT PLEASE READ THOROUGHLY*****

Legal Litigations: If you have an active, planned or possible impending litigation regarding/involving other medical providers or concerning your pain/health condition due to exceptional circumstances, please understand that our practice, Gorman Medical, P.C., and our providers, will not be involved in any legal litigation or provide you care at that time. For example, we will be able to provide care for a patient after a motor vehicle accident, if there is no plan to follow up with a legal litigation or if the case is settled prior to establishing care with our facility. We do not have the resources for medical legal litigations and choose not to be accountable in any legal matter.

PLEASE READ THE NEXT TWO STATEMENTS CARFULLY AND PRINT YOUR NAME ON THE LINE NEXT TO THE STATEMENT THAT IS TRUE. PLEASE DO NOT SIGN BOTH!!!!!

If you DO have an active/impending legal litigation:

I, _____ understand that Gorman Medical, P.C. will not be involved with my care at this time. I will be able to return to clinic if I provide Settlement of Suit documents or settlement papers clearing up my legal litigation.

If you DO NOT have an active/impending legal litigation:

I, _____ do NOT have an active, planned or a possible upcoming litigation regarding/involving other medical providers or concerning my pain/health condition.

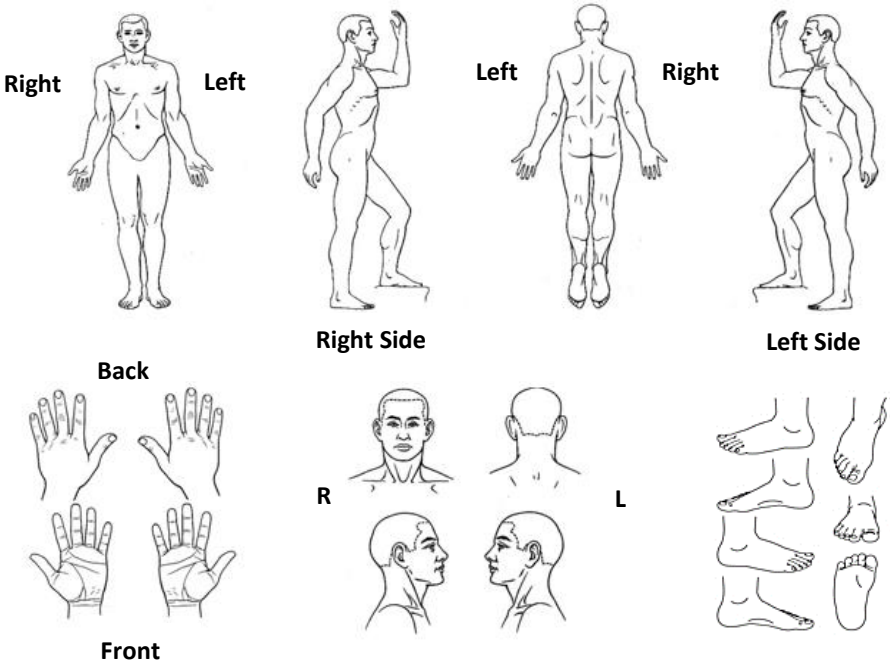
Patient Signature Name: _____ Date: _____

PAIN MANAGEMENT PORTION

PATIENT PRINTED NAME: _____ DATE: _____

1. Where is your pain located? _____

Please indicate, on the diagram below, where your pain is located:



OTHER

2. When did your pain begin? _____

3. How did your pain begin? (i.e. lifting, motor vehicle accident, fall, etc.)

_____

_____

4. What do you believe is causing the pain?

_____

_____

5. Is your pain constant? ☐ Yes ☐ No

6. Which best describes your pain currently:

☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Stabbing

☐Other: _____

Please circle the number on the scale of 1-10 that describes your pain:

0 I 2 3 4 5 6 7 8 9 I0

0 = No pain 10 = Severe pain

7. What make pain worse?

☐ Coughing/Sneezing	☐ Hot/Cold Weather	☐ Damp/Dry Weather
☐ Lifting	☐ Bowel Movement	☐ Stair Climbing
☐ Lying Down	☐ Exercise	☐ Standing
☐ Walking	☐ Sitting	☐ Other

8. What makes your pain better?

☐ Bed Rest	☐ Chiropractor	☐ Physical Therapy
☐ Heat/Cold	☐ Counseling	☐ Relaxation Training
☐ Medication	☐ Exercise Program	☐ Acupuncture
☐ Massage Therapy	☐ Biofeedback	☐ Trigger Point Injections

9. Do you have weakness in your arms or legs? ☐ Yes ☐ No

10. Is the pain better at certain times of the day or night? _____

11. Please describe the effects of your pain:

Accompanying symptoms (e.g. nausea, headaches): _____

Sleep: _____

Appetite: _____

Physical Activity: _____

Relationship with others (e.g. irritability) _____

Emotions (e.g. anger, suicidal thoughts, crying) _____

Concentration _____

Other: _____

12. Have you undergone Nerve Blocks/Pain Procedures?

DATE	PROCEDURE	PHYSICIAN	HOSPITAL	OUTCOME

13. Have you ever had any scans/tests for your pain?

☐ X-rays ☐ CT Scan ☐ MRI ☐Myelogram ☐ EMG ☐ Bone Scan

☐ Other, please specify: _____

PATEINT SIGNATURE: _____ DATE: _____

PAIN MANAGEMENT CONTRACT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management and to prevent misunderstanding about office policies. This Agreement is to help you and your provider to comply with the laws and regulations regarding controlled pharmaceuticals.

↓ Initials

_____ Abusive, unprofessional, uncontrolled behavior results in AUTOMATIC DISMISSAL from the practice.

_____ Our pain management clinic is a LOW DOSE NARCOTIC clinic with use of all other adjunctive pain management methods.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ I agree that I will submit to a drug screen if requested by my provider to determine my compliance with my program of pain control medications.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will provide my provider with updates on medications that are prescribed to me by any other provider, including primary care medications (blood pressure, asthma, diabetic, ADD/ADHD, seizure and psychiatric medications, ect.)

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone, nor will I take/use any controlled opioid medications that are NOT prescribed to me.

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from ANY OTHER PROVIDER.

_____ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being WITHOUT MEDICATION FOR A PERIOD OF TIME. NO EARLY REFILLS!

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED.

_____ I agree to properly dispose of old, unused or discontinued medications. If a medication is discontinued for any reason, I WILL NOT continue to take that medication at the risk of interactions or overdose.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Drug Monitoring Program web site periodically throughout my treatment period.

_____ I understand that refills for pain medications will be made ONLY at the time of an office visit or script refill visit. NO EARLY REFILLS. We DO NOT refill pain medication or prescribe new pain medication over the phone; you must have an appointment.

_____ In an effort to ensure you receive the best possible care, all medication will now be processed and filled by **Cordant Pharmacy Solutions;** a Denver, CO based pharmacy that delivers medications to patients. We are also needing to limit the amount of pharmacies per patient.

For emergency purposes, please choose a local Pharmacy: _____

Address and/or Cross Streets: _____

_____ I understand that **I am ultimately responsible** for scheduling my appointments **prior** to my medication due dates. When scheduling my appointments, I would need to take weather conditions, Cordant delivery time, and unforeseen/emergency situations into consideration. Special circumstances will be considered, however, not guaranteed.

_____ I understand that I need to fill my medication in entirety. If my Pharmacy cannot fill the full quantity of my prescription, I will inform my provider to resolve this issue.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

_____ I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I understand that if I break this Agreement, my provider will STOP PRESCRIBING these pain control medicines.

I was given the opportunity to discuss all my questions and concerns regarding this agreement and my treatment. A copy of this document has been offered to me.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

DRUG SCREENING POLICY

Providers:
Charles H. Ripp, MD
Fran J. Gorman, ANP-C
Tina Gehrke, FNP-C
Elise Musolf, DC, FNP-C

As of January 1st, 2016, our practice is THC (Marijuana) free. Upon visits to our clinic, your provider may request a drug screen to determine compliance with our Pain Management program. If your drug screen is positive for THC at the time of visit, the provider will still see you but may not prescribe any **narcotic** medications.

If drug screen results are not consistent with providers' prescription plan:
Examples:

- Drug screen negative for medications clinic prescribes.
- Patient test positive for controlled substances not prescribed by clinic.
- Patient tests positive for illicit substances, ex: cocaine, heroin, PCP, methamphetamine.

Your drug screen may be sent to Cordant laboratory for further evaluation, at the cost to the patient, and your provider will review the results. Illicit drug use will result in immediate termination from our clinic.

Thank you,

Gorman Medical Staff

Patient Printed Name: _____ Date: _____

Patient Signature: _____

PALLIATIVE CARE CONTRACT

CHRONIC PAIN PALLIATIVE CARE CONTRACT FOR NARCOTIC MEDICATION USE

If your you and your provider have elected to proceed with high dosage COT (chronic opioid or narcotic therapy) please read the following and sign below.

Currently there are 16,000 patients/year in the US dying from routine narcotic prescriptions - generally of the higher dosage requirements. Thus, the FDA, CDC, and formal pain management societies have placed extreme scrutiny on the practice of ROUTINE narcotic prescribing for chronic pain control. The issues have been the amounts prescribed, length prescribed, reasons for prescribing (clinical needs), efficacy, real/actual pain control, development of tolerance, and questionable evidence of long-term efficacy with use of lengthy narcotic scripts (months to years), Functional level improvements (ability to dress, eat, walk, sleep, work, household chores, etc.) need improvements in addition to pain control for prescribing beyond recommended limits (below).

Presently the CDC (Center for Disease Control) recommends maintaining a chronic narcotic dosage limit of 50 mg of Morphine per day or its equivalents in other narcotic medications. 50 mg of morphine equivalent is equal to 33 mg of oxycodone, 50 mg of hydrocodone, or 10 mg of Dilaudid daily by mouth. Additionally, these organizations are highly recommending no other sedative-hypnotic medications ingested while taking narcotics. Prescribing beyond these narcotic script limits despite utilizing much larger amounts for extended periods may cause heart attack, stroke, near death, coma, or death. Therefore, in agreement with your medical provider and the need to administer > 50 Morphine mg equivalents/day to yourself, you have agreed by signing The Chronic Palliative Pain Control Contract that you are of the understanding that your health is at risk for heart attack, stroke, near death, coma or death. Additionally, use of any additional sedative pain control, sleeping or psychiatric medication (anti-depressant or anxiety medication) even though your narcotic dosage is under 50 mg of Morphine equivalents daily places your health at risk for heart attack, stroke, near death, coma or death.

Thus, your medical condition has placed you, due to your narcotic and other sedative medication needs, under a PALLIATIVE chronic pain control regimen. This means that your provider is treating a condition not likely to medically improve, and pain control using narcotic medications is one of the few viable clinical options. Failure to sign this form for your provider will necessitate your scripts be under 50 mg of Morphine or its narcotic equivalents (above). Failure to sign the form will eliminate any non-narcotic adjunctive medication such as Soma, benzodiazepines (Valium/Klonopin/etc.), antidepressant medication (i.e. Prozac), or sleeping medications (such as Ambien) when used with any amounts of narcotics prescribed. Potentially due to OSA (Obstructive Sleep Apnea) or other medical concurrent issues your health may be at risk for heart attack, stroke, near death, coma or death with chronic narcotic treatment at any dosage taken routinely. Thus, the use of narcotic pain medicine and/or sedative adjunctive medications with OSA or other identified serious medical condition places your health at risk for heart attack, stroke, near death, coma or death. This would be considered clinically needed palliative pain control care by prescribing narcotics and other sedative medications with an underlying serious medical condition.

I understand the implications of signing this form and wish to continue my present and recommended PALLIATIVE CARE Regimen of narcotics and adjunctive other sedative medications if clinically needed. I do understand that the prescribing of narcotics and use of additional non-narcotic medications for my condition places myself at risk for heart attack, stroke, near death, coma or death. Any questions regarding this form, please ask your provider.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

THANK YOU FOR ADHERING TO OUR POLICIES