



Patient Number _____

Pharmacy Name _____

Referring Physician _____

Pharmacy Phone Number _____

Primary Care Physician _____

PATIENT INFORMATION

(PLEASE PRINT AND COMPLETE ALL INFORMATION)

Last Name _____ First Name _____ Middle Name _____

Mailing Address _____ Home Phone _____

City _____ Zip _____ Work Phone _____

Date of Birth _____ Age _____ Sex: M F Cell Phone _____

Marital Status (circle one): Single/Divorced/Married/Widow/Separated If applicable, please list your spouse's name: _____

Patient's Place of Employment _____ Patient's Social Security Number _____

Person responsible for payment _____ Retired? Yes No

Mailing Address of responsible party _____

Are you here because of an auto accident or work related accident? Yes No Do you have medical insurance? Yes No

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S) & ID CARD

PRIMARY Insurance _____ SECONDARY Insurance _____

If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:

Name _____ Social Security Number _____

Date of Birth _____ Sex: M F Relationship to Patient _____

Mailing Address _____ City _____

State _____ Zip _____ Employer _____

Do you have a cancer policy? Yes No (If yes please discuss with our Insurance Office)

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

- Release of Information: The physician may disclose all or any part of the patient's records to any person or cooperation which is, or may be liable under contract to the physician or the patient or to a family member or employer of the patient, for all or part of the physician's charge, including, but not limited to, insurance companies, workers compensation carriers, and welfare funds. The physician may also send copies of all or part of the patient's records to any physician that participates in the total medical care of the patient.
- Assignment of Insurance Benefits: In the event the patient is entitled to physician benefits arising out of any policy of insurance insuring patient or any other party liable to the patient, said benefits are hereby assigned to the physician for application on patient's bill, and it is agreed the physician upon receipt of such benefits, shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment and the undersigned and/or patient shall be responsible for all charges not covered by this assignment.
- Medicare / Medicaid Patients Certification: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all my records required to act on this request and that payment of authorized benefits be made directly to the physicians involved in my care and for any services furnished to me requested by said physicians.

Patient / Patient's Representative, if patient unable to sign

Date Relationship

Patient / Patient's Representative, if patient unable to sign

Date Relationship

Patient / Patient's Representative, if patient unable to sign

Date Relationship

**Woodlands Medical Specialists
Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent to Woodlands Medical Specialists to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Woodlands Medical Specialists Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Woodlands Medical Specialists reserves the right to revise its Notice of Privacy Practices at anytime. A Notice of Privacy Practices may be obtained by forwarding a written request to Woodlands Medical Specialists at **4724 North Davis Hwy Pensacola, FL 32503**.

With the consent, Woodlands Medical Specialists may use the following means to contact me regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, billing statements, or any calls pertaining to my clinical care, including laboratory results among others: calling my home or other alternative location and leaving a message on voice mail; emailing my home or other alternative location; sending written mail to my home or other alternative location as long as it is marked "Personal and Confidential."

I wish to be contacted in the following manner (check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with doctor's name and phone number only
<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail my work/office address

<input type="checkbox"/> Other _____ |
|--|--|

I have the right to request that Woodlands Medical Specialists restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Woodlands Medical Specialists use and disclosure of my PHI to carry out TPO.

Woodlands Medical Specialists may disclose PHI to the following individuals:

Name	Relationship	Telephone

I may revoke my consent in writing except to the extent that the practice has already made disclosures bases upon my prior consent. If I do not sign the consent, or later revoke it, Woodlands Medical Specialists may decline to provide treatment to me.

Assignment of Insurance Benefits: In the event the patient is entitled to physician benefits arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the physician for application on patient's bill, and it is agreed the physician, upon receipt of such benefits, shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment and the undersigned or patient shall be responsible for all charges not covered by this agreement.

Medicare/Medicaid Patients Certification: I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act is correct. I authorize the release of all my records required to act on this request and that payment of authorized benefits be made directly to the physicians involved in my care and for any services furnished to me requested by said physician.

I acknowledge that I have received a copy of the photo consent. Please initial. Thank you. _____ (Patient or Legal Guardian)

I do / do not (circle one) authorize the release of information specific to laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions.

Signature of Patient or Legal Guardian

Date

MEDICATION MANAGEMENT AGREEMENT

This contract between _____ (patient) and Woodlands Medical Specialists is our agreement on the clear conditions for the prescriptions and use of pain-controlling medications prescribed by my doctor. We agree that this contract is important and necessary to maintain the trust and confidence required in a doctor/patient relationship. The agreement is to prevent any misunderstanding about the goals and conditions of my treatment with pain medications.

I (patient) agree to accept all the following conditions with regard to pain medication prescribed or provided by my doctor.

I understand that a reduction in the intensity of my pain and improvement in function and my quality of life are the goals of my treatment.

I realize that all of my medications have potential side effects, and I will have the recommended laboratory tests needed to continue the treatment plan as safely as possible.

I realize it is my responsibility to keep others and myself safe from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree that I will not attempt to perform the activity until a doctor has evaluated me or I have not used my medication for at least four days.

I will NOT use any illegal controlled substances, including marijuana, cocaine, etc. or any controlled substances not prescribed by my doctor.

I will NOT share, sell or trade my medication for money, goods, or other services.

I will NOT attempt to get pain medication, stimulants or anti-anxiety medicines from any other physician. I understand that is *against the law* to do so. If another doctor wants to prescribe pain medications for me, my doctor must approve the prescriptions to make sure there is no duplication.

I will STOP all previously used pain medications unless my doctor gives me permission to use them.

I am responsible for my medication. I will guard my medication and keep it safe from loss or theft, and will take it only as prescribed. I will not use my medication up sooner than it is prescribed.

I understand that if I fail to keep my medications safe, I will not have them replaced and I will be without medication for a period of time.

I understand that the long-term advantages of chronic opioid use have not been scientifically determined and that my treatment may change while I am a patient, I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances.

I agree to submit to blood or urine testing when requested by my doctor to determine that I am taking my medicine correctly and abiding by the conditions of this agreement.

I agree to see a pain management specialist if my doctor thinks it is necessary. If I do not attend the appointment, my doctor may decide not to provide treatment for me, and my medication will be tapered off then stopped.

I have been fully informed by my doctor/staff that psychological dependence (addiction) is rare. I know some persons develop a tolerance and need more pain medications to maintain pain control. I know that I will become physically dependent on the medication after several weeks. I understand that when I stop the medication I do so slowly and under medical supervision or I may have withdrawal symptoms.

I agree to give up my right to privacy and confidentially concerning the prescribing of my pain medication. I authorize my doctor and my pharmacy to fully cooperate with city, state, or federal law enforcement agencies, including the Florida/Alabama Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, other doctors or agencies.

I agree to use _____ Pharmacy, located at _____

_____, telephone number _____ for ALL my pain medications. If I change my pharmacy for any reason, I agree to notify my doctor at the time I receive a prescription. I agree to provide my new pharmacy with my prior pharmacy's address and telephone number.

I understand my doctor's refill policy:

1. Refills are provided Monday-Friday, 8AM-5PM only, every 4 weeks, in person.
2. Refills must be requested at least 24 hours ahead if I am not seeing the doctor.
3. Refills ARE NOT given at night or on weekends.
4. Refills are provided by my doctor only. I will not ask other physicians for refills.
5. Refills ARE NOT given for lost, stolen, spilled, misplaced or "used up early" medications. NO EMERGENCY REFILLS.

I fully understand that the consequences of my violating this agreement are that my treatment may end immediately. I understand, also, that if my violation involves illegal activity, I may be reported to appropriate authorities. I HAVE READ this agreement and my doctor or staff has explained it to me. I have had an opportunity to ask questions. I have received a copy of this agreement.

Date

Patient Signature

Witness Signature