DENT NEUROLOGIC INSTITUTE

**716.250.2000 | dentinstitute.com**
**Amherst** | 3980 Sheridan Drive • Amherst, NY 14226
**Batavia** | 35 Batavia City Center • Batavia, NY 14020
**Orchard Park** | 200 Sterling Drive • Orchard Park, NY 14127

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

**Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!**

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

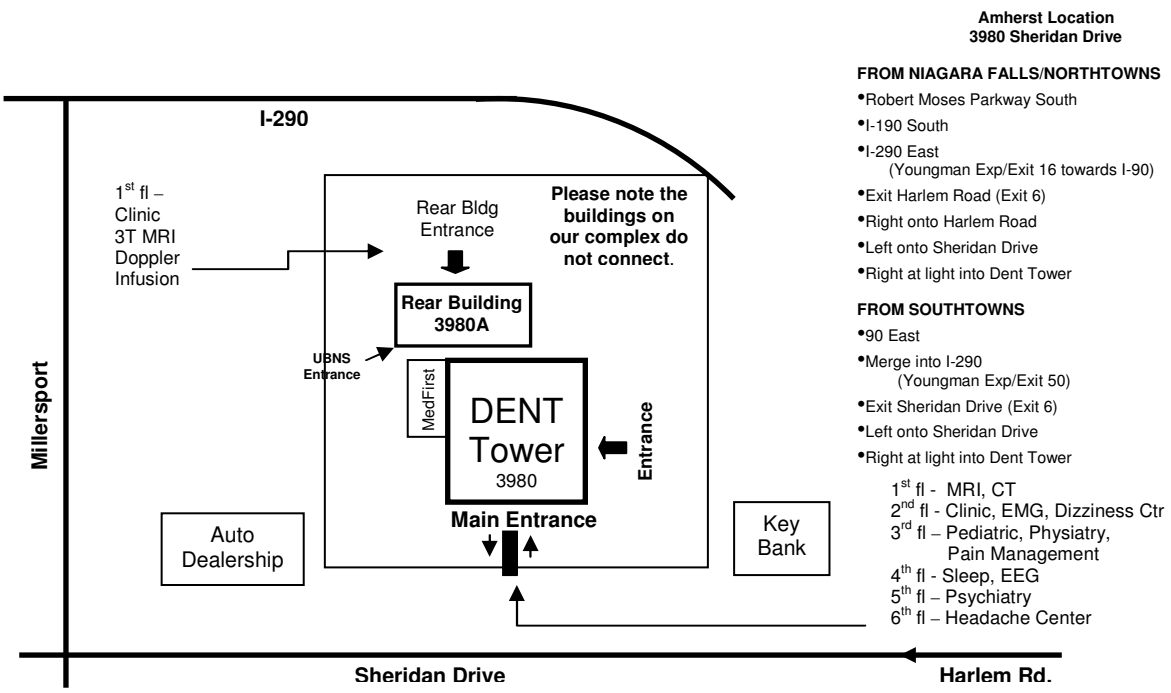
★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit.

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

## Advance Notice is Required for all Cancellations

***If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.***




| | |
|---|---|
| **Orchard Park**<br>200 Sterling Drive<br>Orchard Park, New York 14127<br><br>**FROM SOUTHTOWNS**<br>Route 219 N to Milestrip Road East<br>(1st Exit onto Milestrip Road)<br>Left at traffic light onto Sterling Drive<br>Left on Red Tail<br>Left into parking lot<br><br>**FROM BUFFALO**<br>Thruway (90) West to Route 219<br>Exit Milestrip Road East<br>(2nd Exit onto Milestrip Road)<br>Left at traffic light onto Sterling Drive<br>Left on Red Tail<br>Left into parking lot<br><br>**FROM PENNSYLVANIA**<br>Thruway (90) East to Exit 56<br>Left onto Milestrip Road<br>Left onto Sterling Drive<br>Left on Red Tail<br>Left into parking lot | **Batavia**<br>35 Batavia City Center<br>Batavia, New York 14020<br><br>Located in the<br>Genesee Country Mall<br><br>**Note**: Use entrance on Main Street between the Dental and Insurance offices |

## DENT NEUROLOGIC INSTITUTE 716.250.2000

# DENT NEUROLOGIC INSTITUTE

## REGISTRATION FORM

| | | | | | | |
|---|---|---|---|---|---|---|
| **Today's Date:** | | | | | | |
| **PATIENT INFORMATION** | | | | | | |
| **Last Name:** | **Middle:** | **First:** | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | **Marital Status (circle one):** | |
| | | | | | **Single / Mar / Div / Sep / Wid** | |
| **Former Name:** | | **Birth Date:** | | **Age:** | **Sex:** ❑ M ❑ F | **Transgender:** ❑ T |
| **Street Address or P.O. Box:** | | **E-mail Address:** | | | **Home Phone: ( )** | |
| | | | | | **Cell Phone: ( )** | |
| **City:** | **State:** | **Zip Code:** | | | **Social Security Number:** | |
| **Referring Physician:** | | **Primary Physician:** | | | | |
| **Occupation:** | **Employer:** | | | | **Employer Phone: ( )** | |
| | | | | | ❑ Full Time ❑ Part Time | |
| **Race:** | **Ethnicity:** | | | | **Language:** | |
| **Pharmacy Name:** | **Pharmacy Address:** | | | | **Pharmacy Phone:** | |
| **CONTACT PERSON IN CASE OF EMERGENCY** | | | | | | |
| **Name:** | **Relationship:** | **Home Phone: ( )** | **Work Phone: ( )** | | | |
| **INSURANCE INFORMATION** | | | | | | |
| **You will need to give your insurance card to the receptionist** | | | | | | |
| **Person Responsible for Bill (if not self):** | **Address (if different):** | | | | **Home Phone: ( )** | |
| | | | | | **Cell Phone: ( )** | |
| **Birth Date: / /** | **Occupation:** | | | | | |
| **Responsible Party's Employer:** | **Employer Address:** | | | | **Employer Phone: ( )** | |
| **PRIMARY INSURANCE** | **Insurance Plan:** | | | | | |
| **Policy No:** | | **Group No:** | | | | |
| **Subscriber's Name (if not self):** | **Subscriber's SSN:** | | | | **Co-pay Amount:** | |
| | **Subscribers DOB: / /** | | | | | |
| **Patient's Relationship to Subscriber:** | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | | |
| **SECONDARY INSURANCE** | **Insurance Plan:** | | | | | |
| **Policy No:** | | **Group No:** | | | | |
| **Subscriber's Name (if not self):** | **Subscriber's SSN:** | | | | | |
| | **Subscribers DOB: / /** | | | | | |
| **Patient's Relationship to Subscriber:** | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | | |

**IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,**
***YOU <u>MUST</u> COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM***

# PLEASE READ

## Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

### DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus - Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

### DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

# PLEASE REVIEW AND SIGN OUR PRACTICE POLICIES

**Insurance Information/Assignment of Benefits……** Patients are required to provide DENT with current and accurate insurance information at every visit. Your **FAILURE** to provide us with accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorize DENT to furnish information to insurance carriers concerning your illnesses and treatments and hereby assign all payments for medical services rendered to you or your dependents to Dent Neurologic. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

**Co-Pay, Deductibles, POS Plans, Private Payments and Unpaid Balances...……** In accordance with the provision of your insurance plan, you may be required to pay for a portion or all of your medical services. As a result, if you have a co-pay, deductible, or Point of Service Plan or you are a private paying patient, **payment is required at the time of service.** Should you need to discuss this payment policy, you may contact our Business Office at 250-2010 prior to your appointment. Please note it is within our discretion to take current payments and apply them to existing unpaid balances or move credit balances to future appointments. If for any reason, you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 90 days your account will be turned over to a collection agency, proceedings will begin and you will be discharged from our care. Accounts sent to collections will have a 30% collection fee added to the balance along with applicable attorney fees.

**Identity Theft……** The Federal Trade Commissions, "Red Flag" rule requires health care providers to establish a program to prevent identity theft. As a result we will be asking all patients to provide photo identification when checking in for their appointment and will be taking a photograph to be used for the sole purpose of identification. If you are unable to provide us with proper identification at the time of your visit, we will need to **RESCHEDULE** your appointment.

**Practice Communication Information……..** Patients in our practice may be contacted via phone, email, and/or text messaging to remind of appointments, payment, treatment, and/or other healthcare information. By entering information below, you consent to receiving these communications from us:

| | | | |
|---|---|---|---|
| Send reminders/information (*select all that apply*): | ☐ Voice ( ) - | | |
| | ☐ SMS/text ( ) - | | |
| | ☐ E-mail address: _____<br>*Note: reminders not available via e-mail* | | |
| Preferred Phone Number (**select one**): | ☐ Home | ☐ Cell | ☐ Work |
| Preferred Language (**select one**): | ☐ English | ☐ Spanish | |
| Best time to contact me (**select one**): | ☐ Morning | ☐ Afternoon | ☐ Evening |
| ☐ I do NOT wish to receive any reminders or communications from Dent as outlined above. I understand the cancellation and no show policy as outlined below. | | | |

**Medical Photography……...** Medical photography taken for diagnostic purposes will become a part of your medical record and remain confidential in accordance with regulatory requirements and Dent Policy. From time to time we may use de-identified medical imaging or photography for research or academic purposes. Dent retains all ownership rights in these programs.

**Prescription Refills……..……..…** Patients must contact their pharmacies to request any prescription refills for medications that DENT prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.

**Appointment Cancellation and No Show Policy……** Your scheduled appointment is time reserved especially for you. **We require a minimum of 24-hours advance notice for cancellation or rescheduling of an appointment to allow us to offer this time to other patients**. Rescheduling fees are: $100-Imaging, VNG, Neuropsychology, Sleep Studies. $50-All other appointments.

**General Consent to Treatment and Right to Refuse Treatment..…** By signing below, I (or my authorized representative on my behalf) authorize DENT Neurologic Institute and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving my consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

**I have read and agree to all of the above policies. I understand that my failure to comply with any of these policies may result in discharge from the medical practice.**

Print Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

# Statement of Financial Responsibility

**Insurance Coverage**.* The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of DENT fees. You are ultimately responsible for payment of your bill.

Due to the increasing complexity of insurance plans, DENT requires you to contact your insurer's Member Services for information on your coverage and out-of-pocket costs. For some services, DENT will collect a fee from you before the service is rendered. That amount will be credited against the cost of that service, but in many cases will not cover the full amount. Your insurance plan is the best place to find information on the ultimate cost to you.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. DENT expects these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved service period, you will be responsible for your balance in full.

Your signature below will also authorize your insurer to pay any benefits directly to DENT, the full and entire amount of the bill incurred by you or the named patient, or if applicable, any amount due after payment has been made by your insurance carrier.

**Co-Pay Policy**. It is expected that patients will pay co-pays at the time the service is rendered for each visit, typically during check-in.

**Cancellation / No Show Policy**. DENT understands there may be times when you miss an appointment due to emergencies or other obligations. However, patients who fail to provide adequate cancellation notice, at least 24 hours prior to the appointment time will be assessed a $50 reschedule fee (NOTE: $100 for Sleep Center, Neuropsychology testing and VNG testing appointments). All assessed fees are collected at the time of scheduling the next appointment. Patients will not be able to reschedule an appointment until all fees are paid.

By signing below, you acknowledge that you have read the above policies regarding financial responsibility to DENT for providing health care services to you or the named patient and that you understand and agree to the terms described.

Patient Name (please print): _____ DOB: _____

Patient or Guardian Signature: _____ Date: _____

*Patients with No Fault or Workers Compensation coverage will be handled in compliance with New York State law with regard to payment and benefits.

**HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)**
**DENT NEUROLOGIC INSTITUTE**
**Acknowledgement of Receipt of Privacy Notice**
**And Restrictions/Permissions**

A copy of DENT Neurologic Institute's Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state laws has been made available to me.

I understand the contents of the Notice and I request the following exceptions:

**RESTRICTIONS:**

Please restrict the use and disclosure of my protected health information as follows:

_____
_____
_____
_____

**PERMISSIONS:**

I give permission to the following individuals to view, discuss, exchange, and/or receive my protected health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize DENT Neurologic Institute and the DENT Neurosciences Research Center (DNRC) to access my health data and use my protected health information for clinical research purposes.

_____ **Yes**, DENT and DNRC may use my information to conduct clinical research.

**Initial Here**

***This notice and consent will remain in effect until revoked in writing.***

Patient Name (print): _____ DOB: _____

**Patient Signature:** _____ **Date:** _____

If signed by a person other than the patient, please indicate relationship: _____

***NOTE: Power of Attorney and Legal Guardianship documents are required at the time of your appointment if you are signing on behalf of a patient over the age of 18.***

# DENT NEUROLOGIC INSTITUTE

## WORKERS COMPENSATION

**SUPPLEMENTAL INFORMATION FORM**

| | | |
|---|---|---|
| Today's Date: | Date of Birth: | |
| Patient Name: | Social Security No: | |
| Date of Injury: | | |
| Employer Name: | Employer Address: | |
| Employer Phone Number:<br>( ) | Your Job Title: | Are you out of work due to this injury:<br>❑ Yes ❑ No |

**COMPENSATION INSURANCE CARRIER INFORMATION**

| | |
|---|---|
| Insurance Carrier Name: | Insurance Carrier Address: |
| Carrier Claim Number: | WCB Case Number: |
| Name of Case Manager: | Phone: ( ) |
| | Fax: ( ) |
| Briefly Describe the Injury you Sustained: | |
| Briefly Describe how Injury Occurred: | |

**ATTORNEY INFORMATION**

| | |
|---|---|
| Attorney Name: | Attorney Address: |
| Phone: ( ) | Fax: ( ) |

**Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.**

# DENT NEUROLOGIC INSTITUTE

## NO-FAULT

**SUPPLEMENTAL INFORMATION FORM**

| | |
|---|---|
| Patient Name: | Date of Birth:<br>Social Security No: |
| Date of Accident: | Are You Currently Out of Work as a Result of this Accident:<br>❑ Yes ❑ No |
| Injury Sustained: | |
| **INSURANCE CARRIER INFORMATION** | |
| Insurance Carrier Name: | Insurance Carrier Address: |
| Name of Adjuster: | Claim Number: |
| Phone: ( ) | Fax: ( ) |
| **ACCIDENT DETAILS** | |
| Location of Accident: | |
| Briefly Describe how the Accident Occurred: | |
| Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian | |
| If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted | |
| Have you Filed a Claim with your Carrier:<br>❑ Yes ❑ No | Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No |
| **ATTORNEY INFORMATION** | |
| Attorney Name: | Attorney Address: |
| Phone: ( ) Fax: ( ) | |
| **Signature:** | **Date:** |
| **FOR OFFICE USE ONLY** | |
| **PROVIDER:**<br>**DENT NEUROLOGIC GROUP**<br>**PO Box 8000 Dept 057**<br>**Buffalo, NY 14267**<br><br>**Signature: _____** | **CLAIM# _____**<br>**DATE OF LOSS: _____**<br>**CARRIER: _____** |

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# DENT NEUROLOGIC
## NEW PATIENT HISTORY FORM

**Today's Date** _____

Name: _____ DOB: _____ Age: _____

1. Please describe in your own words what your **pain** is like (Where it is, how it feels, is it constant, does it come and go, etc.)

_____

_____

_____

_____

_____

2a. How long have you had the problem?

_____

_____

2b. What is the cause of the pain?

_____

_____

3a. Who is your **primary physician with address** (if known)?

_____

_____

3b. What physicians have you seen for this problem?

_____

_____

4. List all illnesses and/or hospitalizations/surgeries you have had during your life:

_____ _____

_____ _____

_____ _____

_____ _____

4. List the <u>name and dose for each</u> prescription and over-the-counter medication you are <u>currently</u> taking:

**Drug**:_____ **Dose:**_____

_____ _____

_____ _____

_____ _____

_____ _____

5. Any drug allergy?

| Drug | Reaction |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please check if the previous treatment for pain was helpful or not.

| | | |
|---|---|---|
| Nerve Blocks/Pain Management | ❑Yes ❑ No | Name of Physician _____ |
| Surgery | ❑Yes ❑ No | Name of Surgeon _____ |
| Occupational/Physical Therapy | ❑Yes ❑ No | Name of Therapist _____ |
| Biofeedback | ❑Yes ❑ No | Name of Therapist _____ |
| Hypnosis | ❑Yes ❑ No | Name of Physician _____ |
| Counseling | ❑Yes ❑ No | Name of Physician _____ |
| Chiropractor | ❑Yes ❑ No | Name of Physician _____ |
| TENS Unit | ❑Yes ❑ No | Comments _____ |
| | | _____ |

Print Name: _____

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

| Treatment | Date | Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

7. Other problems? Please **circle** the ones that apply to you:

Neurologic
Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke)

Constitutional
Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes
Blurry vision, double vision, decreased vision, cataract, glaucoma

Ears, Nose, Mouth, Throat
Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning)

Cardiovascular
Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory
Cough, emphysema, asthma.

Gastro-Intestinal
Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis

Genito-Urinary
Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems

Skin
Rash or other skin abnormality

Musculoskeletal
Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric
Depression, anxiety, other psychiatric problems

Print Name: _____

**Continued from # 7**

Endocrine
Diabetes, thyroid problems, hormonal problems

Hematologic
Anemia, easily bruises, bleeding disorder.

Allergy
Itching, rash, swollen lips/tongue.

Have you ever had cancer? ____ No ____ Yes, describe _____

8. Which of the following tests have you had to evaluate your pain problem within the past 6 months to a year? Please list the approximate date of test, the name of the facility, the name of the ordering physician and the results, if known.

| Test | Date | Where | Physician | Results |
|---|---|---|---|---|
| MRI | _____ | _____ | _____ | ❑ Normal ❑Abnormal |
| CT | _____ | _____ | _____ | ❑ Normal ❑Abnormal |
| X-RAY | _____ | _____ | _____ | ❑ Normal ❑Abnormal |
| EMG | _____ | _____ | _____ | ❑ Normal ❑Abnormal |
| MYELOGRAM | _____ | _____ | _____ | ❑ Normal ❑Abnormal |
| BONE SCAN | _____ | _____ | _____ | ❑ Normal ❑Abnormal |
| Other (SPECT/PET, angiogram, biopsy, spinal tap): | | | | |
| _____ | _____ | _____ | _____ | |
| _____ | _____ | _____ | _____ | |

Print Name: _____

9. Do you use tobacco? ___ No ___Yes, pack per day ___, # of years____ Quit date _____

Do you use alcohol? ___ No ___ Yes, amount _____

Who lives with you at home? _____

Describe your work: _____

_____

Disability? _____ No _____ Yes, since _____

10. Tell us about your family's health:

Mother: _____

Father: _____

Brother #1: _____ Sister #1: _____

Brother #2: _____ Sister #2: _____

Brother #3: _____ Sister #3: _____

Brother #4: _____ Sister #4: _____

11. What do you hope to achieve with your doctor?

_____

_____

_____

_____

12. Emergency contact:

Name: _____ Relationship: _____

Phone: _____ Mobile Phone:_____

_____

Print Name

_____ _____

Signature Date

**Tell Us How We're Doing!**
**Visit Our Website at www.dentinstitute.com and take our on-line survey**

For office use only:

BP _____ Pulse _____ Resp. _____ Wt. _____ Ht. _____

**Consent for Medical Records Access**

I, _____, (print name of patient), hereby give permission to DENT Neurologic Institute ("DENT") to access my medical records from the existing treatment I have received under Dr. Ashraf Henry at Pain Management and Headache Medicine – 4227 Maple Road, Amherst NY 14226.

I acknowledge that by signing below my health information will be transferred to DENT for the purposes of continuing treatment of my pain management condition and that without these records I will not be seen by DENT providers, including Dr. Henry.

I understand that my records, in both paper and electronic format, will be now be kept and maintained by DENT in accordance with state and federal law.

I have been a provided with a copy of DENT's Notice of Privacy Practices and policies related to preserving Protected Health Information and patient confidentiality. I further acknowledge that to receive a copy of my medical records, I must follow DENT's Records Release procedures.

I understand that as of the date signed below, my medical records will be integrated with DENT's Electronic Medical Records (EMR) system and that this process cannot be reversed.

**By signing below, I consent to having my records transferred to and accessed by DENT Neurologic Institute.**

_____ _____

Signature of Patient Date

_____

Date of Birth

DENT NEUROLOGIC INSTITUTE

## Controlled Substance Agreement

1. I understand that I am entering into an agreement with my physician to manage my diagnosis with a controlled substance medication. I have been advised that the purpose of this agreement is to avoid misunderstandings about medications I will be taking, and to comply with the law regarding controlled substances.
2. Controlled substances include, but are not limited to: opiate and opiate-like pain medications (codeine, buprenorphine (requires additional contract), hydrocodone, hydromorphone, tapentadol, tramadol, oxycodone, oxymorphone), sedative-hypnotics (zolpidem, zaleplon, zopiclone, chloral hydrate), benzodazeipines (alprazolam, lorazepam, clonazepam, oxazepam, temazepm, diazepam), barbituates or barbiturate-like medications (phenobarbital, carisoprodol), stimulant and stimulant-like medications (amphetamine, methylphenidate, phentermine, modafinil, armodafinil), some anti-seizure medications (lacosamide and pregabalin), and testosterone supplementation.
3. I understand that the purpose of this treatment is to improve my ability to function and/or to reduce pain.
4. I am aware of the potential side effects of controlled substance medications. These are dependent on the type of medication used. Specific concerns with controlled substances include, but are not limited to:
    a. Respiratory depression (breathing too slowly).
    b. Tolerance (require more medication to get the same effect).
    c. Physical and/or psychological dependence (addiction), which means that abruptly stopping the medication can trigger symptoms of withdrawal or cause me to miss it or to crave it.
    d. Physical dependence of newborns whose mothers take these drugs during pregnancy and possible adverse effects on newborns whose mothers take these drugs during pregnancy, varying depending on the type of medication.
    e. For male patients, low testosterone levels. This may affect mood, stamina, sexual desire and physical and sexual performance.
    f. Possibility that the medication will not provide complete relief.
    g. Allergic reaction.
5. I understand all of the risks and benefits of long-term controlled-substance use are not yet known. I am aware that my treatment plan may change and that my physician will advise me of any appropriate treatment changes.
6. I am aware that there are other types of treatments that do not involve the use of controlled substances. These treatments include, but are not limited to: weight control, exercise, avoidance of tobacco and alcohol, physical therapy, massage therapy, biofeedback, cognitive therapy, psychotherapy, use of anti-inflammatory and other non-opioid pain medications, nerve blocks, and surgical treatment. I agree to pursue such treatments if they are recommended.
7. I agree to provide my doctor with a complete and accurate medical history, including my past medical treatment, any other medications (prescription, over-the-counter or herbal supplements) that I am currently taking, and any history of alcohol or drug addiction or dependency. **If I am a female of childbearing age, I agree to inform my doctor immediately if there is a possibility that I might be pregnant.**

Print Name: _____

8. I agree to inform my provider of the identity of all other providers from whom I receive medical treatment and agree to inform my provider of any controlled substance I am currently prescribed or am prescribed in the future. I represent that I currently do not have a problem with substance abuse or dependence and attest that I have informed my provider of any history of substance abuse or dependence.
9. I agree to communicate fully with my doctor about the character and intensity of my symptoms, the effect of the symptoms on my daily life, whether and how the medicine is helping to relieve my symptoms, and any side effects or problems related to the medication that I am taking.
10. I agree to take my medications as prescribed, using them only for the intended purpose. If I take my medication more often or at a higher dosage than prescribed, I understand that I may be without the medication until the expected renewal date. I am aware that overusing my medication, taking it at higher doses than prescribed, mixing medications without my provider's knowledge, or being without my medication for a period of time might result in death.
11. I agree that I will not attempt to obtain nor will I accept any controlled medications that are considered psychotropics, which would include but are not limited to: controlled stimulants, anti-anxiety medicines, or sedatives from any other health care provider. I understand that doing so may endanger my health. I further understand that the only exception to this is if such medication is prescribed while I am admitted to the hospital or with explicit approval of my treating provider as documented in my medical chart.
12. I agree to follow my provider's instructions about engaging in activities that might be dangerous to me, including but not limited to: operating heavy machinery, driving a motor vehicle, performing tasks on a ladder or at any other unprotected height, and taking responsibility for another individual who is unable to care for himself/herself, since these medications can cause increased drowsiness or sleepiness.
13. I agree that I will not use alcohol or <u>any</u> other prescription drugs without my provider's prior knowledge and agreement. I will stop taking any controlled substances I have taken in the past unless my provider tells me to continue taking them. I will <u>not</u> use <u>any</u> illegal substances, including but not limited to: marijuana, cocaine, heroin, or other similar substances.
14. I understand that driving under the influence of prescribed controlled substances or any combination of controlled substances (e.g. alcohol and prescribed controlled substances) will impair my ability to drive and could result in criminal charges such as DUI or DWI. I further understand that if I am arrested or incarcerated due to sale of or misuse of legal or illegal drugs (including alcohol), my provider will no longer refill my prescriptions for controlled substances and that I am to inform my provider of any future or history of legal charges due to the sale of or misuse of legal or illegal drugs (including alcohol).
15. I agree that I will not sell, possess illegally, divert or transport any controlled substances. I further agree not to hoard, share, sell or trade my medication with any other individual.
16. I understand that if illegal, disruptive, or suspicious activity is observed or is suspected by my pharmacy, other treatment providers, or the NYS Prescription Monitoring Program, this will be reported to my provider and may result in termination of treatment.
17. I agree that I will not alter any of my prescriptions. I understand that if I do so, I will be discharged from the practice <u>immediately</u>. I further understand that my prescription is lost, stolen or misplaced, it will not be replaced.

Print Name: _____

18. I agree to safeguard my controlled substance medicine from loss, theft or damage. I understand that if my medications are lost or stolen, they will not be replaced until 30 days from the date that the last prescription was written, unless I can provide explicit proof, such as a police report, that my controlled substance medication was stolen, and then the medication will only be replaced at the discretion of the treating provider.
19. I understand that my medication can be harmful to others, particularly children and animals. I agree to keep the medication in a safe place.
20. I agree to keep and to be on time for all of my scheduled appointments with my provider and to bring all unused controlled medication with me to the office visit if asked. I further agree to contact my provider 48 hours prior to my appointment if I am unable to keep it. I understand that if I miss scheduled appointments, my provider may either refuse to refill a prescription for me or to discontinue my medication. If I believe that I need to be seen before my next scheduled appointment, I agree to contact my provider.
21. I agree to participate actively in any additional therapies my provider recommends. If my provider determines that I have become dependent on controlled substances, I agree to participate in a program for chemical dependency.
22. I agree to submit to a blood, saliva, urine test, or pill count whenever requested by my provider, including at appointments. If I am called in, I agree to appear for these within 48 hours of request. I agree that I am financially responsible for the cost of this testing if not covered by my insurance. *If the results reveal that I have failed to comply with this agreement and my treatment plan, I understand that my provider may elect to decrease or to discontinue my medications or discontinue me from care. I agree not to consume food items, such as poppy seeds, that put me at risk of a false positive drug screen. I understand that poppy seeds may result in a low level morphine level and that this practice will consider this a positive for morphine regardless of poppy seed consumption.
23. I agree not to falsify or to tamper with drug testing in any way. Evidence of falsifying or tampering with a drug test may result in discontinuation of medication or termination of treatment.
24. I agree that a witnessed drug test may be requested, and I agree to comply with this.
25. I agree to allow my provider to contact my other treating physicians with the results of any drug testing.
26. I authorize my provider and my provider's office staff to communicate with my pharmacist regarding my compliance with this agreement.
27. I agree to adhere to the payment policy outlined by this office. *
28. I agree to conduct myself in a courteous manner with all of the staff of this office.
29. I further authorize both my provider(s) and my pharmacist to cooperate fully with any city, county, state or federal law enforcement agencies, the New York State Board of Pharmacy, the Bureau of Controlled Substances, and the federal Drug Enforcement Agency in the investigation of any possible misuse, sale, or diversion of my controlled substance(s). I authorize my provider to provide a copy of this agreement to any of these agencies and to my pharmacy. I understand that I am waiving any applicable privilege, right of privacy or confidentiality concerning requests for my protected health information from these agencies.

Print Name: _____

30. Medication Refills
    a. **Unless requesting medications during your office visit, all requests should be made to your pharmacy.**
    b. **If for some reason your pharmacy requests that you contact your provider, requests may be made only during regular office hours, Monday through Friday. I understand that I must contact my provider one week prior to running out of my medication, and that I must either come to the office to pick up my written prescription or have it mailed to my pharmacy. I agree that should my provider mail a prescription, my provider is not responsible for any lost or stolen prescriptions in the mail and a new prescription may or may not be granted and this will be at the discretion of the provider.**
    c. **Requests will <u>not</u> be honored on nights, weekends, or holidays.**
    d. **Requests will not be honored if I run out early, lose a prescription, or spill/misplace medications.**
    e. **If I need assistance with my prescriptions, I agree to call the office at least 72 hours ahead.**
    f. **I acknowledge that only written prescriptions will be given, and that no emergency controlled prescriptions will be telephoned to the pharmacy.**
    g. **I cannot request a prescription refill if I have not been seen by my provider in the past 12 months.**
31. I agree to use one pharmacy only and to always inform my provider of any change in pharmacy.
32. I understand that my compliance with the terms of this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider's treatment will be based on this agreement. Failure to comply with all of the conditions in this agreement may result in:
    a. Danger to my life and health.
    b. My doctor electing to decrease or to discontinue prescribing any controlled substances. If this occurs, my provider may choose to taper the medicine over a period of several days, to avoid withdrawal symptoms when discontinuing it.
    c. Discharge from my provider's practice.
33. I understand that if I am no longer able to pay for the medication or treatment prescribed for me, I must not my hold provider or Dent Neurologic Institute responsible. *
34. The terms and conditions of this agreement have been fully explained to me. All of my questions and concerns regarding both my treatment and this agreement have been answered to my satisfaction. I have crossed out all paragraphs that do not pertain to me. I have been given a copy of this document.

This agreement is entered into on _____ / _____/ _____

Patient Name: _____ Patient Signature: _____

Provider Name: _____ Provider Signature: _____

Witness Name: _____ Witness Signature: _____

*Patients with No Fault and/or Worker's Compensation will be handled in compliance with New York State law with regard to payment and benefits*