



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 CRITICAL 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.

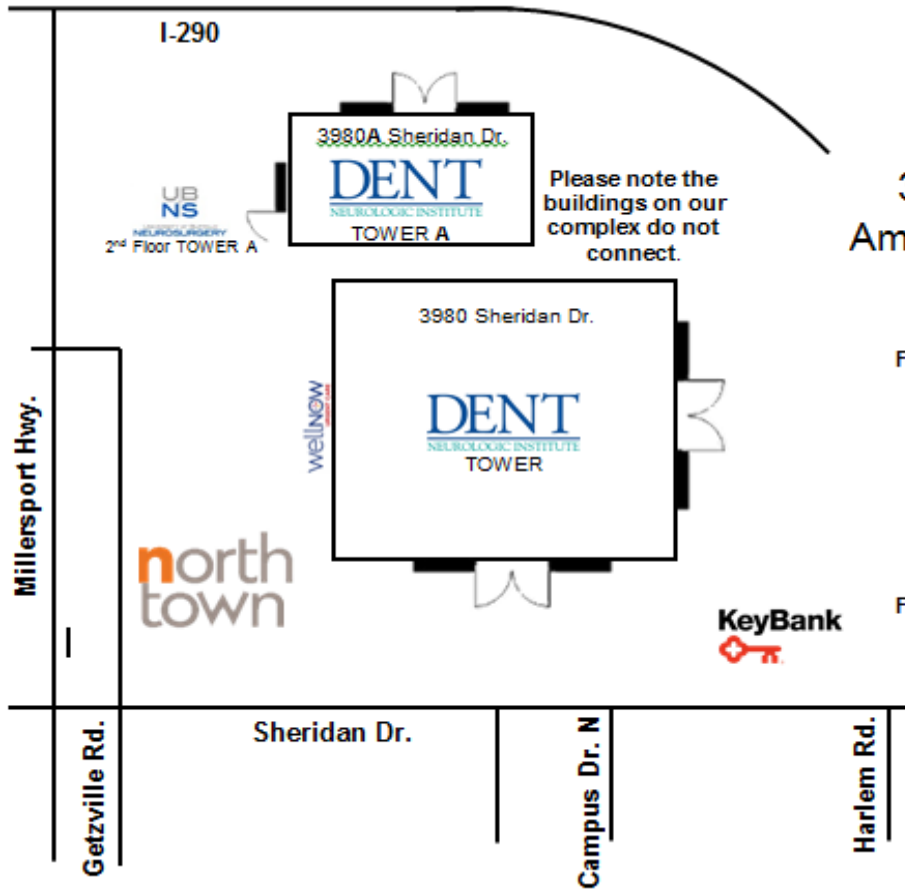
Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

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.

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226



DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTHTOWNS

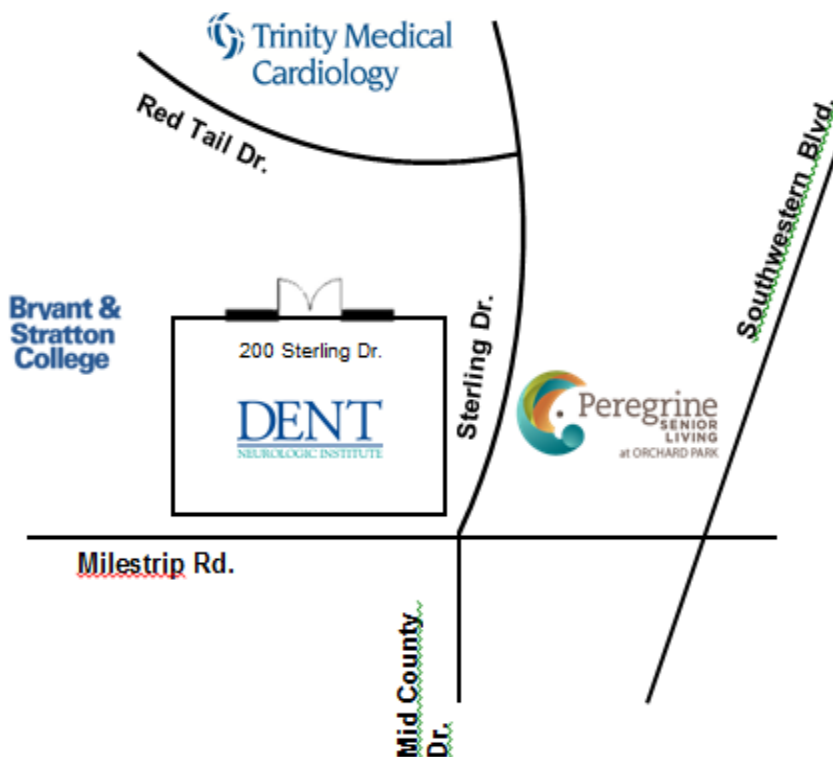
- Robert Moses Parkway South
- I-190 South
- I-290 East
- (Youngman Exp/Exit 16 to wards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- I-190 East
- Merge into I-290
- (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower

Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127



DRIVING DIRECTIONS:

FROM SOUTHTOWNS

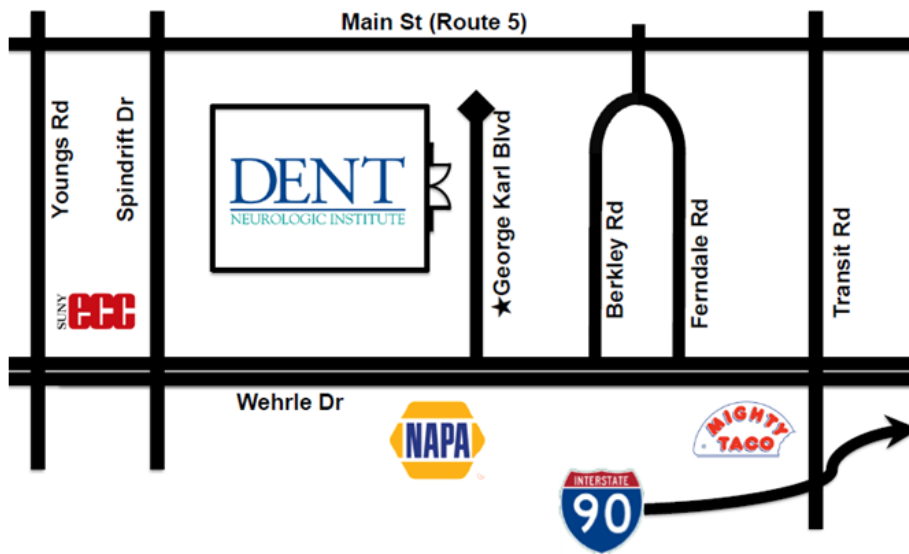
- Route 219 N to Milestrip Road East
- (1st Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

- Thruway (90) West to Route 219
- Exit Milestrip Road East
- (2nd Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot



Buffalo Location
40 George Karl Boulevard
Buffalo, NY 14221
Suite 120

From Niagara Falls

- I-190 South toward Buffalo
- Exit 16 for I-290 East toward Rochester/ Tonawanda
- Take ramp left for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Buffalo

- Route 33 East toward Airport
- Take ramp right for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Southtowns

- Route 219 North toward Buffalo
- Take ramp right for Thruway I-90 East toward Buffalo (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

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DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:		Middle:	First Name:
<input type="checkbox"/> Mr. / <input type="checkbox"/> Mrs. / <input type="checkbox"/> Miss / <input type="checkbox"/> Ms.		Marital Status (Check one):	<input type="checkbox"/> Single / <input type="checkbox"/> Married / <input type="checkbox"/> Divorced <input type="checkbox"/> Separated / <input type="checkbox"/> Widowed
Former Name:		Preferred Name:	
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	E-mail Address:	
Home Phone: ()		Cell Phone: ()	
Street Address or P.O. Box:			
City:	State:	Zip Code:	Social Security Number:
Employer Name:	Employer Address:		Employer Phone: ()
Primary Physician:		Referring Physician:	
Race:	Ethnicity:		Language:
Pharmacy Name:	Pharmacy Address:		Pharmacy Phone:
CONTACT PERSON IN CASE OF EMERGENCY			
Name:		Relationship:	
Home Phone: ()		Cell Phone: ()	
SEXUAL ORIENTATION / GENDER IDENTITY			
Birth Sex (Check one):	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		
Sexual Orientation (Check one):	<input type="checkbox"/> Lesbian, gay or homosexual / <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual / <input type="checkbox"/> Do not know / <input type="checkbox"/> Choose not to disclose		
	Something else, please describe:		
Gender Identity (Check one):	<input type="checkbox"/> Male / <input type="checkbox"/> Female / <input type="checkbox"/> Female-to-Male (FTM), Transgender Male, Trans Man <input type="checkbox"/> Male-to-Female (MTF), Transgender Female, Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Choose not to disclose		
	Additional gender category or other, please specify:		

DENT NEUROLOGIC INSTITUTE

INSURANCE INFORMATION

You will need to give your insurance card to the receptionist			
Last Name:		Middle:	First Name:
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 (Check one):	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> 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 (Check one):	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other

**IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU MUST 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

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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: ()	Your Job Title:	Are you out of work due to this injury: <input type="checkbox"/> Yes <input type="checkbox"/> 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:
		Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian		
If Driver or Passenger, were you: <input type="checkbox"/> Belted <input type="checkbox"/> Not-Belted		
Have you Filed a Claim with your Carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you Completed and Returned your No-Fault Application: <input type="checkbox"/> Yes <input type="checkbox"/> No	
ATTORNEY INFORMATION		
Attorney Name:		Attorney Address:
Phone: ()	Fax: ()	
Signature: _____		Date: _____
FOR OFFICE USE ONLY		
PROVIDER: DENT NEUROLOGIC GROUP PO Box 8000 Dept 057 Buffalo, NY 14267 Signature: _____		CLAIM# _____ DATE OF LOSS: _____ CARRIER: _____

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:

5. List the name and dose for each prescription and over-the-counter medication you are currently taking:

Drug: _____

Dose: _____

6. 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: _____

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

Treatment

Date

Results

<u>Treatment</u>	<u>Date</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. 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: «FirstName» «LastName»

Continued from # 8

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 _____

9. 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.

<u>Test</u>	<u>Date</u>	<u>Where</u>	<u>Physician</u>	<u>Results</u>
MRI	_____	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
CT	_____	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
X-RAY	_____	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
EMG	_____	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
MYELOGRAM	_____	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
BONE SCAN	_____	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Other (SPECT/PET, angiogram, biopsy, spinal tap):				
_____	_____	_____	_____	
_____	_____	_____	_____	

Print Name: _____

10. 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 _____

11. 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: _____

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

13. 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. _____

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Controlled Substance Agreement

1. I understand that I am entering 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 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 substances 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.**

Patient Name: _____

Date of Birth: _____

Controlled Substance Agreement

8. I agree to inform my provider of the identity of all other providers from whom I receive treatment and agree to inform my provider of any controlled substances 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 such medication is prescribed while I am admitted to the hospital or without 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 any 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 not use any illegal substances, including but not limited to: recreational 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 the sale 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 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 immediately. I further understand that if my prescription is lost, stolen or misplaced, it will not be replaced.

Patient Name: _____

Date of Birth: _____

Controlled Substance Agreement

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.
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 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 business 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 of morphine level and that this practice will consider this as 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 I 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 drug testing.
26. I authorize to 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 authorize 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.

Patient Name: _____

Date of Birth: _____

Controlled Substance Agreement

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 not 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 business 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.
- h. I understand that if medical cannabis is recommended as a treatment option, I will discuss with my Pain Management Provider regarding any other prescription for opioid medications. The Pain Management Provider will determine if the medical cannabis can be prescribed simultaneously with opioid medications.

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 death.
- 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 hold my 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: _____

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