Innovative Pain Care Center

P: (702) 316-2281
F: (702) 316-2272
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REGISTRATION FORM

PATIENT INFORMATION				
Date	Referring Physician			
☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last Name	First Name	MI	
Birth Date	Age	SS#	Gender ☐ M ☐ F	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Street Address				
City	State	Zip		
Phone	Cell			
Preferred means of contact ☐ Call ☐ Text ☐ Email:				
May we leave a voice mail? ☐ Yes ☐ No				
Can we leave a message with family member/someone else? ☐ Yes ☐ No				
EMPLOYMENT INFORMATION				
Employer	Cell			
Street Address				
City	State	Zip		
INSURANCE INFORMATION				
Primary Insurance	Policy Start Date			
Member/Policy#	Group Name/Number			
Policyholder's Name	SS#	DOB		
Policyholder's Employer	Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Secondary Insurance	Policy Start Date			
Member/Policy#	Group Name/Number			
Policyholder's Name	SS#	DOB		
Policyholder's Employer	Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other			
IN CASE OF EMERGENCY				
Name	Relation to Patient	Phone		

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ASSIGNMENT AND RELEASE

I understand that any and all fees incurred for medical treatment are my total and ultimate responsibility, regardless of any insurance I may have. It is ultimately my responsibility to know the guidelines of my insurance coverage. In the event that my insurance does not provide benefits or provides reduced benefits and/or I do not provide my insurance company needed information in a timely manner, I will be financially responsible to pay up to the agreed upon fee schedule.

I agree to pay for all services rendered. If a collection agency's services are required, I further agree to pay collection agency fees (35%) and interest at the rate of 1.5% monthly or 18% annually until the debt is paid. I further agree to pay for all legal fees, court costs and reasonable attorney fees associated with collecting any outstanding debt. There will be a $75.00 fee (per incident) added to my bill for redeposit or returned checks.

I, the undersigned, assign directly to **Innovative Pain Care Center**, medical benefits, if any, from my insurance carrier that would otherwise be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and/or further medical treatments. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Patient or Responsible Party Signature **Date**

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PAIN MANAGEMENT QUESTIONNAIRES

The following are some questions given to all patients at **Innovative Pain Care Center** who are on or being considered for opioids for their pain. There are 3 sections to complete. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Section 1 of 3: OPIOID RISK TOOL

Please complete one column according to your gender and check the number in the column if your answer is "yes".

Mark each box that applies	Female	Male
Family History of Substance Abuse		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Rx Drugs	☐ 4	☐ 4
Personal History of Substance Abuse		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Rx Drugs	☐ 5	☐ 5
Age between 16-45 years	☐ 1	☐ 1
History of preadolescent sexual abuse	☐ 3	☐ 0
Psychological Disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals		

Patient Signature _____ **Patient Name** _____ **Date** _____

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Name _____ **Date of Birth** _____ **Today's Date** _____

SECTION 2 of 3: PATIENT HEALTH QUESTIONNAIRES - 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓ " to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
Moving or speaking so slowly that other people have noticed? Or, the opposite: being so fidgety or restless that you've been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING 0 + _____ + _____ + _____

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult**

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The following are some questions given to all patients at **Innovative Pain Care Center** who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

(Use "✓ " to indicate your answer)

SECTION 3 of 3: SOAPP-R	Never	Seldom	Sometimes	Often	Very Often
How often do you have mood swings?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt a need for higher doses of medication to treat your pain?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt impatient with your doctors?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt that things are just too overwhelming that you can't handle them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often is there tension in the home?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you counted pain pills to see how many are remaining?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been concerned that people will judge you for taking pain medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often do you feel bored?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you taken more pain medication than you were supposed to?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you worried about being left alone?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you felt a craving for medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others expressed concern over your use of medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have any of your close friends had a problem with alcohol or drugs?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others told you that you had a bad temper?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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Name _____ **Date of Birth** _____ **Today's Date** _____

Cont. Section 3 of 3: SOAPP-R	Never	Seldom	Sometimes	Often	Very Often
How often have you felt consumed by the need to get pain medication?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you run out of pain medication early?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others kept you from getting what you deserve?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often, in your lifetime, have you had legal problems or been arrested?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you attended an AA or NA meeting?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been in an argument that was so out of control that someone got hurt?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been sexually abused?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have others suggested that you have a drug or alcohol problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you had to borrow pain medications from your family or friends?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
How often have you been treated for an alcohol or drug problem?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

SOAPP Score _____

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CONTROLLED SUBSTANCE QUESTIONNAIRE

Questions	Yes	No	N/A
Have you ever used a controlled substance in a way other than prescribed?	☐	☐	☐
Have you ever diverted a controlled substance to another person?	☐	☐	☐
Have you ever taken a controlled substance that did not have the desired effect?	☐	☐	☐
Are you currently using any drugs, including alcohol or marijuana?	☐	☐	☐
Are you using any drugs that may negatively interact with a controlled substance?	☐	☐	☐
Are you using any drugs that were not prescribed by a practitioner that is treating you?	☐	☐	☐
Have you ever attempted to obtain an early refill of a controlled substance?	☐	☐	☐
Have you ever made a claim that a controlled substance was lost or stolen?	☐	☐	☐
Have you ever been questioned about your pharmacy report or PMP report?	☐	☐	☐
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	☐	☐	☐
Have you ever been accused of inappropriate behavior or intoxication?	☐	☐	☐
Have you ever increased the dose or frequency of meds without telling your provider?	☐	☐	☐
Have you ever had difficulty with stopping the use of a controlled substance?	☐	☐	☐
Have you ever demanded to be prescribed a controlled substance?	☐	☐	☐
Have you ever refused to cooperate with any medical testing or examinations?	☐	☐	☐
Have you ever had a history of substance abuse of any kind?	☐	☐	☐
Has there been any change in your health that might affect your medications?	☐	☐	☐
Have you misused or become addicted to a drug, or failed to comply with instructions?	☐	☐	☐
Are there any other factors that your practitioner should consider before prescribing?	☐	☐	☐

Patient's Signature _____ Patient Name _____ Date _____

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NECK PAIN AND DISABILITY QUESTIONNAIRE

Rate the severity of your pain by checking a number: **0** (No Pain) **1 2 3 4 5 6 7 8 9 10** (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (WASHING, DRESSING, ETC.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ I am slow and careful because it is painful for me to look after myself.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weight without extra pain.
- ☐ I can lift heavy weight but it causes extra pain.
- ☐ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like a table.
- ☐ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I cannot lift any weight due to neck pain.

SECTION 4 - READING

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight neck pain.
- ☐ I can read as much as I want to with moderate neck pain.
- ☐ I cannot read as much as I want to due to moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.

SECTION 5 - HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that occur infrequently.
- ☐ I have moderate headaches that occur infrequently.
- ☐ I have frequent moderate headaches.
- ☐ I have frequent severe headaches.
- ☐ I have severe headaches all the time.

SECTION 6 - CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

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SECTION 7- WORK

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can barely do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all.

SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed. (less than 1hour sleepless)
- ☐ My sleep is mildly disturbed. (1hour sleepless)
- ☐ My sleep is moderately disturbed. (2 to 3 hours sleepless)
- ☐ My sleep is greatly disturbed. (4 to 5 hours sleepless)
- ☐ My sleep is completely disturbed. (6 to 7 hours sleepless)

SECTION 10 - RECREATION

- ☐ I am able to engage in all recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most, but not all of my usual recreation activities.
- ☐ I am able to engage in a few of my usual recreation activities.
- ☐ I can hardly do any recreation activities.
- ☐ I cannot do any recreation activities due to neck pain.

Patient Signature	Patient Name	Date

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_____ x2 =	_____	_____
Total Points	**Disability Percentage**	**Rating Scale**

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OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE (WASHING, DRESSING, ETC.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. On a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - WALKING

- ☐ Pain doesn’t prevent me walking any distance.
- ☐ Pain prevents me from walking more than 1mile.
- ☐ Pain prevents me from walking more than 1/2mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

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SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7- SLEEPING

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SEX LIFE (IF APPLICABLE)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 - SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sport.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 - TRAVELLING

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to receive treatments.

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PRESCRIPTION MEDICATION AGREEMENT FOR CONTROLLED SUBSTANCE THERAPY FOR PAIN

Nevada law requires a patient to enter into a "Prescription Medication Agreement" if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities that my practitioner has made me aware of. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please sign below to indicate your understanding of all parts of this document.)

1. **I understand my overall treatment plan and I understand the goals of the treatment of pain, including the appropriate use of a controlled substance.**

- I have discussed my treatment plan with my practitioner, **Innovative Pain Care Center**: **Dr. Daniel Burkhead**, **Dr. Ho Dzung**, **Dr. Willis Wu**, **Dr. Ryan West**, **Michael Scott, PA-C**, **Neil Jones, PA-C**, **Kelsee Chang, FNP-C**, and I have a good understanding of the overall treatment plan and goals of treatment. My practitioner has discussed possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that continuation of a controlled substance for more than 30 days may provide some benefit for the treatment of my pain. I may be continued on controlled substance(s); including opioids.
- I understand that part of the goals of my pain management therapy may likely include attempts to minimize or discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend tapering or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means, the presence or development of side effects, any signs of misuse, abuse, diversion, or addiction, refusal to comply with diagnostic studies or other aspects of the treatment plan, attempts to obtain medication from another provider, use of illicit drugs or other medications that may interact with the controlled substance, or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.
- I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children and I will dispose of unused medication appropriately.
- I understand that controlled substances can cause certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing, and possibly fatal overdose. Due to this risk of fatal overdose, the antidote naloxone (Narcan®) is available, without a prescription, at pharmacies.

- I understand that while taking these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.
- I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, tolerance, dependence, and addiction.

2. **It is my responsibility to maintain compliance with my treatment plan.**

- I will keep, and be on time for, all scheduled appointments with my practitioner.
- I understand that prescriptions will only be provided scheduled office visits, and it is my responsibility to make sure that I have scheduled an appointment for refills (typically 30 days in advance). I understand that a minimum of a 5-7day notice may be necessary to get in for an appointment for medication refills. I will not call between appointments, at night, or on weekends to attempt to obtain refills.
- I understand that my medication is my responsibility and if it is lost or stolen, the medication will not be replaced until my next appointment and may not replaced at all.
- I will treat the office staff respectfully at all times and I may be subject to discharge from the clinic if I am disrespectful to staff or disruptive to the care of others.
- If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

3. **It is my responsibility to communicate important information to my practitioner.**

- I agree to inform my practitioner if I have ever taken a controlled substance in the past, and if it provided the intended effect. I will also inform my practitioner if I am ever given a prescription for a controlled substance by another provider, prior to filling or taking that medication.
- I will inform my practitioner if I use alcohol, marijuana, or any other illicit drugs.
- I will inform my practitioner if I have ever been treated for side effects or complications relating to the use of controlled substances.
- If I or anyone in my family has had problems with mental illness or with abuse or misuse of alcohol or other drugs, I will inform my practitioner, as this may put me at greater risk of developing an addiction. I will also inform my practitioner of any change in my health status, any new medications that have been prescribed, or any other circumstances which may impact my usage of a controlled substance.

4. **I understand that I am strictly prohibited from sharing the controlled substance with anyone or giving or selling the medication to any other person.**

5. **I understand that, as part of my treatment monitoring, periodic body fluid testing (urine, blood, saliva, etc.) may be required at the discretion of my practitioner. I will consent to such monitoring when deemed necessary by my practitioner.**

- I agree to come in to the clinic for such monitoring and testing within 24 hours of being contacted

by the office, and if I refuse or am unable to do so, then my treatment with controlled substances may be discontinued, at the discretion of the practitioner.

- I agree to bring any and all vials of my current medications to the office within 24 hours of being contacted, in order to have my practitioner perform a pill count.

6. **I agree to sign a release form to let my practitioner obtain records from other clinics and speak to other practitioners about my current or prior medical care.**

- It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.
- I will keep up to date with any bills from the office, and I will inform the office of any change in my health insurance or payment method. I agree to pay the copayment or coinsurance fees required by my insurer at the time of service.
- I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Medical, Dental, or Nursing Boards.

7. **I agree to fill all of my prescription from only one pharmacy. My pharmacy is:**

Pharmacy Name _____ Phone Number _____

Pharmacy Address _____

8. **I understand that Nevada state law requires me to provide a listing of every state in which I have previously resided, or had a prescription for a controlled substance filled. Below is a listing of such states:**

_____ _____

_____ _____

_____ _____

9. **I understand that if I violate any part of this agreement, then I may be denied prescriptions for controlled substances and I may be discharged from the clinic.**

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of the Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain condition.

Patient Signature	**Patient Name**	**Date**
Parent/Guardian Signatue	**Parent/Guardian Name**	**Date**

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WRITTEN INFORMED CONSENT FOR CONTROLLED SUBSTANCE THERAPY FOR PAIN

Nevada law requires a patient's informed consent before a controlled substance can be initially prescribed to treat the patient's pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities that my practitioner has made me aware of. The purpose of this agreement is to help both me and my practitioner comply with the law.

(Please sign below to indicate your understanding of all parts of this document.)

1. **It is my responsibility to maintain compliance with my practitioner's treatment plan. This includes the responsibility of using the controlled substance properly, as prescribed, and taking the medication as directed.**

- I have discussed my treatment plan with my practitioner, **Innovative Pain Care Center**: **Dr. Daniel Burkhead**, **Dr. Ho Dzung**, **Dr. Wills Wu**, **Dr. Ryan West**, **Michael Scott, PA-C**, **Neil Jones, PA-C**, **Kelsee Chang, FNP-C**, and I have a good understanding of the overall treatment plan and goals of treatment. I may be given prescriptions for controlled substances; including opioids. My practitioner has discussed specific risks and benefits of these drugs as well as possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that a controlled substance may provide some benefit for the treatment of my pain.
- I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.
- When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.
- I understand my practitioner's protocol for addressing any requests for refills.
- If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

2. **It is my responsibility to understand the risks and benefits of using a controlled substance, including the possibility of addiction.**

- There are potential risks and benefits associated with the use of controlled substances for the treatment of pain and I understand these risks and benefits regarding the medication that I've been prescribed.
- I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing.
- Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises.
- I understand that I may become physically dependent these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep disruption.

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- I understand that there is a risk of addiction to controlled substances. If I cannot control my usage of the medication then I may be referred for addiction treatment.
- I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana) this risk is increased.
- Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone (Narcan®) is available, without a prescription, and I can obtain this medication from a pharmacist at any time.
- I have been made aware that there are controlled substances designed to deter abuse available to me and are risks and benefits associated with those drugs.

3. **It is my responsibility to communicate important information to my practitioner.**
   If I or anyone in my family has had problems with mental illness or with abuse or misuse of alcohol or other drugs, I will inform my practitioner, as this may put me at greater risk of developing an addiction. I will also inform my practitioner of any change in my health status or any other circumstance which may impact my usage of medication.
4. **It is my responsibility to store and dispose of controlled substances in the appropriate manner.**
   Prescriptions for controlled substances should always be stored in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a “drug-take back day” station, or I may safely dispose of them by dissolving them in a “Dettera” bag, which may be available for purchase at a pharmacy.
5. **For Women (ages 15-45):** It is my responsibility to tell my practitioner if I am or have reason to believe that I am pregnant or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).
6. **For the Parent or Guardian of un-emancipated minor:** In addition to the above, there are risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person and I have an understanding about ways to detect such abuse, misuse or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I give my consent for the prescription of controlled substances to treat pain condition.

Patient Signature	**Patient Name**	**Date**
Parent/Guardian Signature	**Parent/Guardian Name**	**Date**

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HIPAA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Innovative Pain Care Center is committed to HIPAA regulations. Therefore each patient is required to sign a release. Patients may include companion(s) (family members, friends, etc.) accompanying them to their appointment, schedule or reschedule appointments. Listed individuals are approved to hear discussion regarding the patient's health information.

I authorize the following individuals to be involved in the discussion of my medical health information. I understand I am responsible for the release of information provided by **Innovative Pain Care Center** to the following:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Name **Date**

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Date _____

Dear Primary Care Provider / Referring Provider _____

This letter is intended to inform you of the ongoing pain management care of our mutual patient, _____.

This patient has been continuing treatment in our chronic pain management clinic. The treatment plan may consist of a combination of physical modalities, medication management, and interventional procedures, possibly including steroid injections. The rationale for continuation of these treatments involves the patient's preference to avoid surgery. If repeat steroid injections are employed, they will be repeated only if the patient has had a recurrence of pain in the same location that was previously relived with similar steroid injections for at least 3 months. It is our judgment that the benefits of additional steroid injections outweigh the risks of repeated steroid administration.

Please do not hesitate to contact our clinic with any questions.

Sincerely,

Innovative Pain Care Center

Dr. Daniel Burkhead, MD | Dr. Ho Dzung, MD | Dr. Willis Wu, MD | Dr. Ryan West, DO

Please provide our office with your Primary Care Physician Information or Referring Doctor Information if you do not have a Primary Care Physician. New Insurance Guidelines require us to inform your primary care physician or referring physician of ongoing treatment.

Primary Care Physician / Referring Physician Information:

Name _____

Phone _____ Fax _____

HIPAA PRIVACY AUTHORIZATION RELEASE

I authorize Innovative Pain Care Center to release information to my medical provider listed above.

_____ _____

Patient Name **Patient Signature**