Bluegrass
Pain Consultants, PLLC

PHONE: 502-423-1021
FAX: 502-423-1416
www.bluegrasspain.com

WELCOME to ***Bluegrass Pain Consultants, PLLC!*** Our staff extends our most heartfelt greetings to you and commits to bring you the best care available in the Kentuckiana area. We are dedicated to providing you with a multidisciplinary care approach to meet your needs. Our goal is to be professional, courteous, and compassionate in all that we do to serve you.

This new patient information includes various forms that we need you to complete in order for us to plan your health care needs. Therefore, it is important for you to complete the information packet and bring it with you on your scheduled appointment. **Failure to bring these forms and any other information requested hampers our ability to give you the best care and possibly may result in rescheduling your appointment.**

We are excited that you have chosen us to provide your pain management care.

Appointment _____

(Please call 502-423-1021 for any questions you may have)

Location for your appointment will be at:

☐ **Springs Medical Center- Lower Level**
6400 Dutchmans Parkway, Suite 60
Louisville, KY 40205

☐ **LaGrange**
1009 New Moody Lane
LaGrange, KY 40031

☐ **Champion Farms**
10241 Champion Farms Dr.
Louisville, KY 40241

☐ **Springs Medical Center- First Floor**
6420 Dutchmans Parkway, Suite 170
Louisville, KY 40205

Welcome to Bluegrass Pain Consultants!

We would like to take this opportunity to advise you about our billing and insurance processes. We want you to have an excellent experience with us and would like to proactively clarify what we need to successfully process your claims.

At each visit you will need:

- Your current insurance card (if you also have secondary or tertiary insurance, present that card as well).
- Verify that your name on your patient account matches the name on your insurance card exactly.
- Your current photo identification.
- Verify your correct address and phone number is on file with our office.

Co-pays, Deductibles and Co-insurance:

- Co-pays are required at the time of service and vary based on your insurance and visit type.
- We accept cash, checks and credit/debit cards.
- If you need to make payment arrangements for deductibles or co-insurance amounts, please contact our internal billing team.
- If you pay your current balance due in full, we will offer a 10% discount.
- If you write a check and it is returned for insufficient funds, there will be a $25.00 fee in addition to the amount of the check. We will not accept check payments for future visits.
- If your account has a balance, you will be asked to pay towards the balance at your visit and/or be asked to set-up a payment plan.
- Visit www.bluegrasspain.com and click on the General Info Tab to make an online payment using your debit/credit card.

If you need to cancel an office visit or procedure:

- Please provide at least a 24 hour notice. There is a $45.00 charge for no show office visits and $100.00 charge for no show procedure appointments.

If you have a HMO (Health Maintenance Insurance):

- You are required to obtain a referral before you can be seen, this can be obtained from your primary care physician.
- Referrals are only approved for a certain number of visits or timeframe. Be sure your referral is current at each visit.

If you are having a procedure:

- Our staff will obtain a pre-cert prior to your visit.
- We encourage you to contact your insurance company prior to your appointment to obtain the amount of the co-insurance or monies due relative to the portion of the charge that is your financial responsibility. Our billing staff can assist as needed.
- Bluegrass Pain Consultants is not responsible for lost or stolen personal items brought onto the property. It is the sole responsibility of the patient to keep track of their personal items.

Insurance plans:

- We accept most major insurance plans, including Medicare, Medicare Replacements and Passport.
- We do not currently accept self-pay.
- Billing statements are mailed on a monthly basis. If you have not received a statement, please contact our billing team and they can provide a copy for you.

If you have any questions regarding your bill or insurance we would be happy to assist. You can contact our office and leave a brief description of your request and a daytime phone number and we will return your call within 24 business hours.

Billing staff (internal): 502-423-1021 and ask for billing.

Please sign below as acknowledgement of our processes and policies.

Patient Name: _____ **Date:** _____

Thank you for choosing Bluegrass Pain Consultants!

BGP-73

BLUEGRASS PAIN CONSULTANTS, PLLC
Tel: 502-423-1021 Fax: 502-423-1416

HISTORY FORM

Today's Date_____ Last Name_____ First Name_____ MI_____

Height _____Weight_____ Living Status ☐ Married ☐ Divorced ☐ Single ☐ Lives with significant other ☐ Widowed ☐ Separated

PCP (Primary Care Physician) _____
Address _____ Telephone #_____

Referring Physician _____
Address _____ Telephone #_____

Chief Complaint (What is the **main reason** for your visit today?)

_____
_____
_____
_____
_____
_____

Date of accident or date symptoms began? _____
Was this a work related accident? ☐ Yes ☐ No
Was this an auto accident? ☐ Yes ☐ No
Accident other than above? ☐ Yes ☐ No If yes, please explain:

_____
_____

Describe the symptoms you are having: _____
_____

Does the problem interfere with your normal functions? ☐ Yes ☐ No If yes, please explain: _____
_____

Are you currently working? ☐ Yes ☐ No If yes, are you working: ☐ Full day ☐ Light duty

List any other doctors you have seen for this problem: _____

List any previous tests for this problem (MRI, CT scan, X-Ray please list date done)

_____
_____
_____

Any previous therapies/treatments tried for this problem (physical therapy, chiropractor, epidural injections, other injections, etc.): _____
_____

Bluegrass Pain Consultants, PLLC

Patient Label

OFFICE ASSESSMENT

Patient last seen on, for ☐ Office Visit ☐ Procedure ☐ Other _____

If last **seen for procedure,** what **type,** any **relief,** and **how long?** _____

☐ Current Medication reviewed with patient today.

Are you pregnant/could you possibly be pregnant? ☐ Yes ☐ No

Allergies/Reactions _____

Pain Assessment

Pain Score: Present ____ Worse ____ Best ____ Chief Complaint: _____

Is this a new problem? ☐ Yes ☐ No ☐ N/A

If same problem, progress from last visit? ☐ Improved by _____% ☐ Worse ☐ Same (no improvement)

Quality: Shooting /Aching /Stabbing / Burning /Throbbing /Sharp / Dull /Hot / Cold /Other: _____

Duration: Constant /Most of time / Intermittent / Occasionally/ Rare/ Other: _____

What decreases pain _____ What increases pain _____

Associated signs/symptoms: weakness /numbness /tingling **Associated Morbidities:** ☐ Stroke ☐ Cancer ☐ Hypertension ☐ Thyroid

Location: _____ ☐ Diabetes ☐ Asthma ☐ COPD ☐ GERD ☐ MI ☐ _____

Appetite: ☐ No change ☐ Increased ☐ Decreased Physical Activity: ☐ No change ☐ Increased ☐ Decreased

Sleep: ☐ No problem ☐ Interrupted ☐ Insomnia Concentration: ☐ No difficulty ☐ Difficulty

Signature _____ Date _____ Time _____

Exam

General Appearance: ___WNL __ Other_____

Mental Status: __Alert ___Oriented x3 __ Other_____

ENT: __ PERRLA ___Normocephalic

__No masses appreciated Other_____

Neck __Supple ___ No Masses appreciated __ Other_____

Cranial Nerve Testing: __II-XII Grossly Intact ___Other _____

Carotid: __2+ and equal bilaterally __ No bruits on auscultation
___No lymphadenopathy __ Other_____

Lungs: ___Clear __Diminished __Rhonchi/Wheezing Other_____
Heart: __SR __Murmurs Other_____

Abdomen: __Soft and Non Tender __ Bowel sounds present by auscultation __No Masses appreciated Other _____

Cervical Spine: A.F. _____ Extension _____
Rotation _____ Other_____
Cervical Tenderness: _____

Upper extremities: Motor _____ Sensory _____
DTR's _____ Other _____

Lumbosacral A.F. _____ Extension_____
Rotation: _____ Other _____
Lumbosacral Tenderness: _____

Lower Extremities: Motor_____ Sensory _____
DTR'S _____ SLR _____
Other_____

Genitalia/Rectum: ____WNL _____Abnormal_____

Abnormal and relevant Negative Findings:

Disposition/Treatment Plan

Medication Management: __ No change / Other_____ Procedure Today: _____

PA Signature: _____ MD Signature: _____Date_____ Time _____

(Rev. 2/12)

Patient Name: _____ Date of Birth: _____

HISTORY OF CONSERVATIVE THERAPIES

PLEASE INDICATE IF YOU HAVE PARTICIPATED IN ANY OF THE FOLLOWING CONSERVATIVE THERAPIES:

	DATES FROM	TO	NECK	SHOULDERS	ARMS	HANDS	BACK	LEGS	FEET	INCREASED PAIN	NO RELIEF	MINIMAL RELIEF	FULL RELIEF
PHYSICAL THERAPY			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CHIROPRACTIC CARE			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ACUPUNCTURE			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
TRIGGER POINT INJECTIONS			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
TENS UNIT			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HOME EXERCISE PROGRAM			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER _____			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

WERE ANY OF THESE THERAPIES DISCONTINUED BECAUSE OF NEGATIVE SIDE EFFECTS? PLEASE SPECIFY WHICH TREATMENTS AND DESCRIBE THE EFFECTS:

_____

_____

_____ _____

SIGNATURE DATE

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ANSWERS TO FREQUENTLY ASKED QUESTIONS

- It is the patient's responsibility to secure a referral from his or her primary physician. It is also the patient's responsibility to ensure that their insurance is in network with our facility.
- **All patients are required to submit co-pay/co-insurance on the day of their visit.** Checks should be made payable to: Bluegrass Pain Consultants (BPC). We also accept all major credit cards.
- There is a $50.00 fee to fill out medical forms such as but not limited to: short term disability, accident/insurance forms, requests from attorneys, medical assessment forms. This fee is due at the time of request. Please understand that it may take up to 14 days from the time of request before form may be completed.
- If you are more than 15 minutes late to your scheduled appointment, you will be rescheduled.
- We have a 72 hour cancellation policy prior to any scheduled appointment time (including new patient evaluations). Late cancellations affect our ability to schedule other patients in a timely fashion.
- Prescriptions requests received after 11:00 AM on Friday may not be filled until the following Friday. Prescriptions will not be filled after clinic hours, weekends, or holidays. **We need at least 5-7 business day notice for prescription refills. Any prescription(s) request that we are not allowed to fax/call in will require you to pick up from the clinic location you are seen at (We do not mail prescriptions)**
- ***Please keep track of your medication so you can plan accordingly.***

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NEW PATIENT INSTRUCTIONS

1. Arrive 30 minutes prior to your scheduled appointment to allow time for completion of assessment forms. Co-Pays/Co-Insurance are due, the day of your appointment, as required by insurance company.

2. If you are on antibiotics or anti-coagulant medications or blood thinners such as Plavix, Lovenox, Heparin, Coumadin, Aggrenox or Ticlid it is important that you inform us.

3. Please bring in a current list of your daily medication(s) including all vitamins and herbal medications.

4. Please bring a valid picture ID along with your insurance card(s). All of the information on these cards must match.

5. Have all recent study reports (MRI's, CAT scans, etc.)faxed to our office prior to your appointment. Our fax number is 502-423-1416.

We thank you for taking the time to review these instructions which will help us to provide you with the best possible care.

With prescribing medications as a possibility in your plan of care our goal is your safety first and foremost. Therefore, you will be required to follow the guidelines as it pertains to our practices use of prescribed medication. Please review and adhere to the following protocols for prescription(s).

1. Give our office 5-7 business days (Mon-Fri) notice for all refills
2. Please contact our office prior to any pharmacy changes-a new medicaition agreement must be signed.
3. We cannot give medicine changes over the phone
4. We will call you once your prescription is ready for pick-up if your medication is one that cannot be called in.
5. If you miss your regularly scheduled appointment, this can/may result in denial of your prescription refill until you are seen by our office (this is KY state law).

Bluegrass
Pain Consultants, PLLC

NOTICE OF PRIVACY PRACTICES

Effective June, 2008

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information"(PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by Bluegrass Pain Consultants. The purpose of this notice is to explain who, what, when, where and why your PHI may be used so disclosed, and assist you in making informed decisions when authorizing anyone to use or disclose your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEATLH INOFRMATION

- To request in writing to the treatment area a restriction on the uses and disclosures of PHI as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosure that do not require your authorization.
- To obtain a paper copy of this Notice and upon written request submitted to the Bluegrass Pain Consultants facility maintaining the record, inspect and/or obtain a copy of your health record.
- To amend your health record by submitting a written request with the reasons supporting the request to the Medical Records department. We may deny your request if a) the record was not created by us, unless the person who created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.
- To request in writing to the Privacy Officer a written list of disclosure we made of your health information, except that we are not required to account for disclosure for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.
- To request in writing the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by e-mail, fax, and/or telephone.
- To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be in writing to the Medical Records unit of the facility where you originally filed your authorization.

OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all your PHI, including information obtained prior to the change.
- Post notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/COMPLAINTS/REQUESTS

Direct your questions, complaints and requests made pursuant to this notice to: Bluegrass Pain Consultants. You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes: **Treatment:** We may use and disclose your PHI to anyone involved in the provision of health care to you, including for example, physicians, nurse, practitioners nurses, and other medical professional, including our medical students, residents and volunteers. We may also disclose your PHI to outside treating medical professionals and staff as deemed necessary for your health care. **Payment** We may use and disclose your PHI to billing and collection agencies, insurance companies and health plans to collect payment for our services. **Health Care Operations:** We may use and disclose your PHI for our own health care operations. For example, we may use your PHI to assess your care in an effort to improve the quality of our service to you; to evaluate the skills, qualifications and performance of our care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your PHI to assist our compliance with applicable law. **Business Associates:** There are some services provided to our organization through contracts with business associates such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards. **Individuals Involved With Your Care:** We may disclose your PHI to family or others identified by you or who are involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contracting the caregiver at the facility providing your care. **Legally Required Disclosure & Public Health:** We may disclose PHI as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths. **Health Oversight Activities:** We may disclose your PHI to a federal or state health oversight agency that is authorized to oversee our operations. **Workers Compensation:** We may disclose PHI for Workers Compensation or similar programs. **Law Enforcement & Subpoena:** We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crimes, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena. **Inmates:** We may disclose your PHI to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or c) for the safety and security of the correctional facility. **Information Regarding Decedents:** We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties, and 3) procurement organizations for purposes of organ and tissue donation. **Research:** We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization. **Marketing & Fund Raising:** We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort. **Directory Information:** We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting the Registration Office/Desk at the facility from which you received this Notice. **Appointment Reminders:** We may use and disclose your PHI to provide a reminder to you about an appointment. **Treatment Alternatives:** We may use and disclose your PHI to contact you about treatment alternatives that may be of interest to you.

Disclosure Requiring Authorization

All other disclosures of your PHI will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

Changes To This Notice

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI that we maintain by posting the revised Notice at our facilities, making copies or the revised Notice upon request to the facility or the Privacy Officer, or posting the revised notice on our website: www.bluegrasspain.com

TURN PAGE OVER FOR PATIENT'S BILL OF RIGHTS

Bluegrass
Pain Consultants, PLLC

PATIENT REGISTRATION FORM

Preferred Language: □ English □ Other _____

Last Name: _____ First Name _____ MI: _____

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

Home Phone#: ( ) _____ Cell Phone#: ( ) _____ Work #: ( ) _____

DOB: _____ Sex: Male Female SS#: _____ Age: _____

Marital Status: Married Single Other _____

Employment Status: Employed Full time Part-time □ Unemployed □ Disabled □ Retired Student

Place of employment _____ Address _____

Phone # _____

Emergency Contact: _____ Relationship ( ) Phone # _____

Referring Physician: _____ Phone: ( ) _____

Was this a work related injury? Yes No / or **was this motor vehicle accident?** Yes No

(Must have a letter of protection from attorney at time of visit for motor vehicle accident)

Date of injury: _____ Claim #: _____

Employer: _____ Phone # _____

Case Manager: _____ Phone #: ( ) _____ Fax: ( ) _____

Insurance Company: _____ Phone #: ( ) _____

Name and phone # of Attorney and/ or Insurance Agent:

Last Name: _____ First Name: _____

Phone #: ( ) _____ Fax #: ( ) _____

Insurance Information:

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to patient: _____

Policy Holder SS# _____ Policy Holder DOB: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to patient _____

Consent of Treatment

I the patient, or authorized person, do authorize the release of information of any medical information necessary to process claims. I also request payment of government and/or insurance company benefits to myself or to the party who accepts assignment.

Signature: _____ **Printed Name** _____ **Date:** _____

Bluegrass
Pain Consultants, PLLC

Release of Information

I authorize the release of my condition, billing information and/or the pickup of my prescription(s) to the following individuals:

For pick up of my prescription(s):

_____ Relationship_____

_____ Relationship _____

_____ Relationship _____

For my condition and/or billing information only:

_____ Relationship _____

_____ Relationship _____

☐ I authorize Bluegrass Pain Consultants to leave voice messages.

This agreement shall remain in effect until we receive written notice of termination and have requested to fill out a new release.

_____ _____

Signature **Date**

Patient label

Bluegrass
Pain Consultants, PLLC

I understand that as part of my health care, Bluegrass Pain Consultants and its affiliates originate and maintain health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as :

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and medical treatment information to my bill
- a means by which third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

Bluegrass Pain Consultants and its affiliates ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The Notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify Bluegrass Pain Consultants and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I have been provided with a *Notice of Privacy Practices* and have been given the opportunity to review this information.

_____

Signature of Patient or Legal Representative **Date**

_____

Witness **Date**

Bluegrass Pain Consultants, PLLC

Patient Agreement for the use of Controlled Drugs

Controlled drugs and their use are closely monitored by local, state, and federal agencies. Examples of controlled drugs include, but not limited to: narcotics, stimulants, benzodiazepine tranquillizers and barbiturate sedatives. Controlled drugs have a mood-altering effect and pose risks for causing an addictive disorder if misused. Misuse (using more than the prescribed dose or using illicit drugs) can lead to conditions of ***physical dependence*** (tremors, slurred speech, change in appetite or sleep pattern and impaired coordination- to name a few) and ***psychological dependence*** (change in attitude, sudden mood swings, irritable, anxious or paranoid with no reason-to name a few).

The medication(s) that have been prescribed constitute a portion of my treatment plan. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day. I understand that for continued treatment at BLUEGRASS PAIN CONSULTANTS it is necessary for me to observe strict rules pertaining to the use of prescribed medication, and I agree to follow the terms and procedures described in this Agreement.

- I will take medications at the dose and frequency prescribed, and will not exceed the maximum prescribed dose.
- I agree not to alter my medication in any way, and will take my medication whole and it will not be broken, chewed, crushed, injected, or snorted.
- I understand that these drugs should not be stopped abruptly, as withdrawal symptoms may develop.
- I will arrange for refills at the prescribed interval **ONLY** during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or on weekends.
- I will obtain all refills for these medications only at _____ (pharmacy) phone number _____, with full consent for my provider and pharmacist to exchange information in writing or verbally. Should the need arise to change pharmacy; I will inform my physician ***before*** changing pharmacy.
- I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking.
- I will inform my other healthcare providers that I am taking these medications and of the existence of this agreement. In event of an emergency, I will provide this same information to emergency department providers.
- I understand that lost, damaged or stolen prescriptions will not be replaced.
- I am aware that attempting to obtain a controlled substance under pretense is illegal.
- I understand that KASPER(report of controlled substance prescriptions dispensed) is now part of my medical records
- I will keep medications only for my own use and will not share them with others. *The sharing of medications with anyone is absolutely forbidden and is against the law.*

Patient Name: _____ Social Security #: _____ Date: _____

Informed Consent for Controlled Substance Therapy

In the event that the physicians at Bluegrass Pain Consultants, PLLC, initiate treatment with controlled substances (including opiates, sleeping pills, nerve pills) to increase your comfort and improve your quality of life, you are required to read and sign this form. Treatment with controlled substances is an important decision since this treatment approach does have risks, the most common of which are listed below.

Risks

1. Constipation and /or urinary problems.
2. Nausea and/or decreased appetite.
3. Breathing too slowly: overdose can lead to respiratory arrest and death.
4. Confusion or other alteration in thinking and alertness.
5. Coordination/balance problems that may make it unsafe to operate dangerous equipment or motor vehicles.
6. Increased sleepiness or drowsiness.
7. Sexual difficulties including impotence or diminished sex drive.
8. Physical dependence: if you stop the medication abruptly you may experience a withdrawal syndrome characterized by one or more of the following: runny nose, anxiety, diarrhea, abdominal cramping, and/or goose flesh.
9. Psychological dependence: continuing the medication causes you to miss or crave the medication.
10. Tolerance: you may require higher doses of the medication to achieve the same results.
11. Children born to mothers prescribed controlled substances are likely to be born with physical dependence on other controlled substances.
12. Other less common risks and side effects are possible.

Any time it is written "Bluegrass Pain Consultants, PLLC", this refers to any of the physicians within the practice.

We are willing to initiate controlled substance therapy under the following conditions to which you must attest:

Initial:

___ 1.) I do **not** have problems with substance abuse/dependence (including alcohol, illegal drugs, and/or medications).

___ 2.) I have never been involved in the sale, illegal possession, diversion, or transport of controlled substances (opiates, sleeping pills, nerve pills).

___ 3.) I certify that I am not pregnant now and I will notify the physician's at Bluegrass Pain Consultants, PLLC, if I am planning a pregnancy or become pregnant.

___ 4.) I consent to receive prescriptions for **all** pain medications from only the physicians at Bluegrass Pain Consultants, PLLC.

___ 5.) I consent not to order pain medications from another provider via the Internet.

___ 6.) I consent to have my prescription prescribed by physicians at Bluegrass Pain Consultants, PLLC filled by only one pharmacy. I consent to supply the name, address, and phone number of this pharmacy to Bluegrass Pain Consultants, PLLC.

___ 7.) I consent to attend all scheduled appointments with the physicians at Bluegrass Pain Consultants, PLLC. I understand that prescriptions will be dispensed **only** after a scheduled office visit. I understand that 24-hour advance notice is required if I am unable to meet a scheduled appointment.

___ 8.) I consent to notify the physicians at Bluegrass Pain Consultants, PLLC of an emergent need to see another physician (e.g. dental procedures, surgery, and/or emergency room visits) that may require or have required a change in my controlled substance dose. I also consent to notify Bluegrass Pain Consultants, PLLC of the dispensing pharmacy utilized in an emergency.

___ 9.) I consent to follow the schedule of medication as prescribed. I understand that there will be **no** early refills prior to your next scheduled appointment.

___ 10.) I consent to allow the physicians at Bluegrass Pain Consultants, PLLC to communicate with my referring physician, primary care physician, and/or pharmacist regarding my treatment plan, controlled substance medication and results of tests.

___ 11.) I understand that medications prescribed to me by my physician may have side effects and/or may impair my ability to function or perform tasks such as driving, etc. I also understand it is my decision to take such medication and appropriate measures to avoid injury to others or myself.

___ 12.) I consent to the advice of the physicians at Bluegrass Pain Consultants, PLLC regarding the operation of motor vehicles and other equipment while under treatment with controlled substance medications.

___ 13.) I agree to abide by my physician's orders, the manufacturer's directions/warnings, and/or the pharmacists directions/labels/warnings in taking the medication, due to possible side effects, drug interactions, etc. with medication I am prescribed and choose to take.

___ 14.) I consent **not** to share medications with other individuals.

___ 15.) I consent those prescriptions, which are lost, stolen, or accidentally disposed of, will **not** be refilled until the next scheduled appointment.

___ 16.) I consent that I will abstain from using **any** illicit substance while under treatment at Bluegrass Pain Consultants, PLLC (marijuana, cocaine, etc.). If I test positive for such substances, there may be a change in my treatment plan or I may be discharged.

___ 17.) I consent to submit a urine/blood screen at the request of the physicians at Bluegrass Pain Consultants, PLLC to assess my compliance with the treatment plan and to ensure that no illicit substances are being used.

___ 18.) I consent that if an exacerbation of pain is not effectively managed with a limited increase in controlled substance medication, I may be referred for an inpatient pain admission.

___ 19.) I consent that if the physician is concerned regarding my physical/psychological dependence on the controlled substance medication that I may be referred for an inpatient admission, or I may be referred to a specialist in substance abuse/dependence.

___ 20.) I consent that any violation of the conditions established in this consent may result in my pain medication(s) being discontinued over an appropriate period of time, in a change in my treatment plan and/or in me being discharged from Bluegrass Pain Consultants, PLLC.

Please note that by signing this form, you will not automatically become a candidate for controlled substances. Instead, in the event you do become a candidate, this form is intended to educate you and obtain you consent for treatment with controlled substances.

I have read this document, including the above stated risks, understand it, and have had all of my questions answered satisfactory in regards to controlled substances to manage my pain, and understand that my treatment with controlled substances will be in the conditions stated above.

Patient Name: _____ **Date:** _____

Patient Address: _____

Patient Phone Number: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____