PLEASE PROVIDE US WITH THE FOLLOWING PERSONAL AND OTHER PERTINENT INFORMATION

Today's date: ________________________

Name: ____ Nick-name preferred: ________________________

Date of Birth: ________________________ O Male O Female SSN: _______________________________

Mailing address: ____

City, State, Zip: ____ Home Phone: _______________________

Cell Phone: _________________________ Email: ____

Occupation: ____

Employer: ____ Work Phone: ________________________

Is it ok to call you at work? O Yes O No

Employer's Address: ____

City, State, Zip: ____

Name of Referring Physician: ____

Name of Primary Care Physician: ____

Do you currently have a Chiropractic Physician? O Yes O No Name:___________________________

Preferred Pharmacy: ____

Emergency Contact Name: ________________________________ Phone Number: ________________________

FINANCIAL	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
Name		
Address		
City, State, Zip		
Policy #		
Insured Name		
Relation		
SSN		
Birthdate		
Group #		
Employer Name		

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

____

Patient Signature Date

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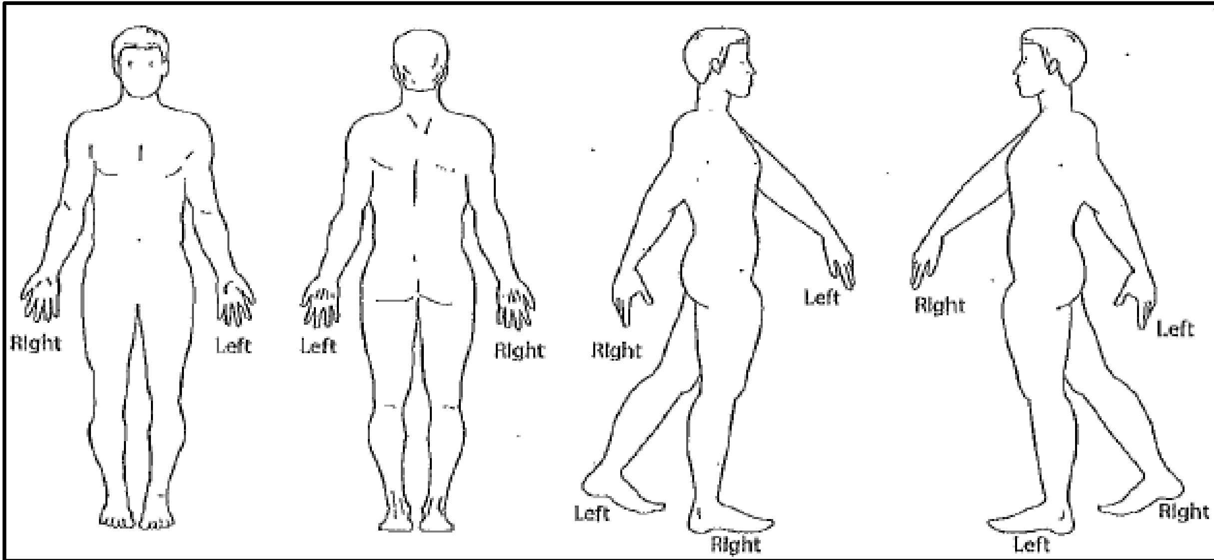
Please shade in the areas on the diagram where your present pain is located. (*please be careful to distinguish right from left*)



If "0" represents NO pain and "10" represents the WORST pain imaginable (*i.e. childbirth or surgery without anesthesia*)**, circle the number that best describes the average pain you have had over the past 7 days:**

0	1	2	3	4	5	6	7	8	9	10
Mild			Moderate			Severe			Emergent	

______________________________ Signature

______________________________ Date

Words that best describe your pain:		
❒ Dull	❒ Fatigued	❒ Pins/Needles
❒ Aching	❒ Bloated	❒ Burning
❒ Throbbing	❒ Sharp	❒ Itching
❒ Catching	❒ Stabbing	❒ Cold
❒ Tight	❒ Shooting	❒ Wet
❒ Cramping	❒ Electric	❒ Twisting/Contorted
❒ Pressure	❒ Numb	
❒ Heavy	❒ Tingling	
Pain Intensity:		
❒ Mild	❒ Fluctuating	
❒ Moderate	❒ Limits activity	
❒ Severe	❒ Limits sleep	
❒ Miserable	❒ Affects mood	
❒ Annoying	❒ Affects relationships	
❒ Distracting	❒ Affects your job	
Associated Symptoms:		
❒ Muscle Weakness	❒ Rash	❒ Constipation
❒ Loss of Bowel/Bladder Control	❒ Itching	❒ Diarrhea
❒ Fevers/Chills	❒ Muscle Spasm	
❒ Nausea/Vomiting	❒ Insomnia/Difficulty Sleeping	
❒ Depression/Anxiety	❒ Daytime Sleepiness	
Pain worsened by:		
❒ Standing	❒ Squatting	❒ Having sex (intercourse)
❒ Walking	❒ Turning in bed	❒ Menstrual Cycle
❒ Sitting	❒ Rise from seated	❒ Cough/Sneeze
❒ Lying Down	❒ Climb/Descend stairs	❒ Urination
❒ Bending	❒ Heat	❒ Bowel Movement
❒ Reaching	❒ Cold	❒ Other
❒ Lifting	❒ Eating/Drinking	
Pain improved by:		
❒ Activity/Distraction	❒ Standing	❒ Cold Application
❒ Medications	❒ Walking	❒ Drinking
❒ Changing Position	❒ Sitting	❒ Menstrual Cycle
❒ Stretching	❒ Lying Down	❒ Passing Urine
❒ Massage	❒ Squatting	❒ Bowel movement
❒ Exercise	❒ Rise from seated	❒ Injections
❒ PT	❒ Eating	❒ Other
❒ Chiropractic	❒ Heat Application	
Pain Timing:		
❒ Constant	❒ Worse at time of Sleep	
❒ Intermittent	❒ Worse with Specific Activity	
❒ Random/Unpredictable	❒ Worsening with Time	
❒ Worse in Morning	❒ Improving with Time	
❒ Worse in Daytime	❒ Waxing/Waning	
❒ Worse in Evening/Nightime		
Pain Onset:		
❒ Sudden with Known Injury	❒ Slowly Over Time	
❒ Sudden without Known Injury	❒ Related to Disease Process	

PAIN HISTORY: How long have you had this pain? ______________________________

PREVIOUS PAIN TREATMENTS: (*Circle all that apply, place a star next to all helpful treatments*).

Injections/Nerve Blocks	Chiropractic Care	Massage/Acupressure	
Pain Clinic	TENS Unit	Acupuncture	Hypnosis
Deep Muscle Stimulation	Pain Psychologist/CBT	Traction	Surgery
Spinal Cord Stimulation	Intrathecal Pain Pump		

Physical Therapy: When? _____________ # of Visits? _________ Benefit? Y / N

PREVIOUS TESTING: (*Please list the date and place they were performed*).

PROCEDURE	DATE(S)	PLACE PERFORMED	For What?
X-Rays			
CT/MRI			
Myelogram			
Ultrasound			
NCV/EMG			

CURRENT MEDICATIONS: (*Please list all medications you are currently taking, Prescription and Over the Counter*).

Name of medication and strength (Please list # of doses per day)	

Are you on a blood thinner? Y / N Which?

FAMILY HISTORY: *Has anyone in your immediate family [mother, father, grandparents, brothers, sisters, children*] been diagnosed with the following conditions.

Heart Disease	Who: ____________________	Rheumatoid Arthritis	Who: ____________________
Hypertension	Who: ____________________	Lupus	Who: ____________________
Stroke	Who: ____________________	Bleeding disorders	Who: ____________________
Cancer	Who: ____________________	Kidney disease	Who: ____________________
Diabetes	Who: ____________________	Neurologic disease	Who: ____________________

MEDICAL HISTORY:

Medical Conditions: *please check and/or list all illnesses/conditions you have been diagnosed with.*

O Shingles/Post herpetic neuralgia ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Surgeries: *please check and/or list all surgeries and the month/year they were performed* .

O History of spinal surgery ______ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Allergies: Medications:____

Food: ____

Check all that apply: O Latex O IV Contrast/Dye O Betadine/Iodine O Adhesive Tape

SOCIAL HISTORY:	Do you smoke, use tobacco or e-cigs?	Y / N	Packs/day?_________________
	Do you drink alcohol?	Y / N	Drinks/day? ________________
	Do you use street drugs *(THC, cocaine, etc)* ?	Y / N	Which? ___________________
	Have you been treated for drug abuse?	Y / N	Where? ___________________
	Are you currently involved in or planning a claim/lawsuit for:		
	Workman's Compensation?	Y / N	
	Personal Injury/Insurance?	Y / N	
	Other?	Y / N	________________
	Are you on/applying for disability?	Y / N	

WOMEN ONLY:	Can you become pregnant?	Y / N	If not, why?____________
	Are you now or could you be pregnant?	Y / N	
	Date of last period: _________________		Normal: YES NO

REVIEW OF SYSTEMS: (*Check any and all that apply*).

SYSTEMIC:
- ❒ Recent weight loss
- ❒ Recent weight gain
- ❒ Fever
- ❒ Chills
- ❒ Night sweats
- ❒ Fatigue

CARDIOVASCULAR:
- ❒ Chest pain
- ❒ Shortness of breath
- ❒ Increased heart rate
- ❒ Swelling of feet/legs

PULMONARY:
- ❒ Dry Cough
- ❒ Productive cough
- ❒ Coughing up blood
- ❒ Difficulty breathing
- ❒ Wheezing

GI:
- ❒ Constipation
- ❒ Diarrhea
- ❒ Blood in stool
- ❒ Abdominal pain
- ❒ Decreased appetite
- ❒ Nausea
- ❒ Vomiting
- ❒ Jaundice

ENDOCRINE:
- ❒ Heat intolerance
- ❒ Cold intolerance
- ❒ Increased thirst
- ❒ Urinary frequency

HEMATOLOGIC:
- ❒ Pallor (pale)
- ❒ Easy bleeding
- ❒ Easy bruising
- ❒ Bleeding gums

MUSCULOSKELETAL:
- ❒ Joint pain
- ❒ Joint stiffness
- ❒ Buckling of knee(s)
- ❒ Buckling of hip(s)
- ❒ Muscle aches
- ❒ Muscle pain
- ❒ Swollen joints

NEUROLOGICAL:
- ❒ Numbness
- ❒ Weakness
- ❒ Balance difficulty
- ❒ Difficulty sleeping
- ❒ Tremor
- ❒ Seizure
- ❒ Fainting
- ❒ Sleepiness
- ❒ Confusion
- ❒ Memory loss

PSYCHOLOGICAL:
- ❒ Depression
- ❒ Anxiety
- ❒ Nervousness
- ❒ Hearing voices
- ❒ Hallucinations
- ❒ Suicidal thoughts

SKIN:
- ❒ Rash
- ❒ Itching
- ❒ Dry skin
- ❒ Hair symptoms
- ❒ Nail symptoms
- ❒ Excessive sweating
- ❒ Erythema
- ❒ Swelling/mass/lump
- ❒ Infection
- ❒ Ulcer

______________________________ Signature

____________________ Date

______________________________ Print Name

____________________ DOB

SOAPP-R Screening Questionnaire

Please answer each question as honestly as possible. There are no right or wrong answers. Answer each question and check only one box per question.	0 - Never	1 - Seldom	2 - Sometimes	3 - Often	4 - Very Often
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension at home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you have a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

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Circle the one number that describes how, during the past week, pain has interfered with your:

a. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

b. Mood

0 1 2 3 4 5 6 7 8 9 10

c. Walking ability

0 1 2 3 4 5 6 7 8 9 10

d. Normal work (includes both outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

e. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

f. Sleep

0 1 2 3 4 5 6 7 8 9 10

g. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere *Completely interferes*

*Name:*______________________________ *DOB:*____________________

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

Patient's Name or Authorized Agent (Please Print) ______________________________

I acknowledge receipt of the physician's Notice of Privacy Practice which provides detailed information about how the office may use and disclose my confidential information.

I hereby give my consent to Synergy Healthcare Solutions to use and disclose, for the purpose of carrying out treatment, payment, or Health Care Operations (TPO), all information contained in my patient record.

With this consent, Synergy Healthcare Solutions may call my home or other alternate locations and leave a message on the answering machine, voicemail, text message or in person in reference to confidential information items that assist the practice in appointment reminders, insurance information items and any calls pertaining to my clinical care, including laboratory or x-ray/MRI results among others.

I may revoke my consent to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Synergy Healthcare Solutions may decline to provide treatment to me.

I understand that this information may include any and all treatment plans, medication, DNA testing, AIDS infection, sexually transmitted diseases, HIV infection, behavioral health service/psychiatric care and evaluations, treatment for alcohol and/or drug abuse or similar conditions.

I authorize Synergy Healthcare Solutions to release protected health information to my family member(s)/other individual(s) listed below:

Name	**Relationship**	**Contact Number**

Signature of Patient: ______________________________ Date: ______________

Do not release the following information: ______________________________________

____

Financial Policy

If you have medical insurance, we want to help you receive your allowable benefits. We need your assistance and understanding of our financial policy.

- You and your insurance carrier are responsible for your bill. Knowing your insurance benefits is your responsibility.
- It is your responsibility to make sure the insurance information we have is active and current.
- You must present your insurance card and a photo ID at every appointment.
- If your insurance changes call the office immediately to ensure all reauthorizations and referrals can be obtained before your appointment. If you arrive for your appointment and your insurance has changed, and a referral or preauthorization is required, your appointment will be rescheduled and you will be charged a $25.00 rescheduling fee that must be paid prior to being seen for your next appointment.
- Payment is expected for all co-payments on the day of your appointment. We are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you are not able to pay your co-pay, you will not be seen, your visit will be rescheduled, and you will be charged a $25.00 rescheduling fee.
- As a courtesy to you we will file your primary and secondary insurance. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.
- Once your insurance has paid, you will receive two statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process, unless prior arrangements are made with our financial office.
- Not all services will be covered by your insurance company. Your policy may contain plan specific limitations that apply to referrals, referral dates and the number of visits. We will make every effort to obtain coverage for services before treatment. However, this does not guarantee payment from your insurance carrier. You may be responsible for payment of these services.
- Synergy Healthcare Solutions will appeal any denials by your insurance company for services rendered on your behalf.
- For services that are not covered by insurance, we require payment in full on or before the day of service for the total estimated charges unless prior payment arrangements have been made with this office.
- If you do not have insurance and are self-pay, payment is expected at the time of service. If you are unable to pay, your appointment will be rescheduled and you will be charged a $25.00 rescheduling fee that must be paid prior to your next appointment.
- In the event your account must be turned over for outside collections, you will be billed for all fees involved in the collection process. Returned check fee is $25.00 and must be paid prior to being seen in the office by credit or debit card or money order.
- There is a $50.00 charge for completing FMLA, handicap license plate placard, disability or accident forms. These forms will be completed during a forms completion appointment with the provider. A functional capacity evaluation will be required for all disability requests. Payment must be paid prior to picking up the completed forms. Please check with the front desk for the rate for any other form.

Missed Appointment Policy

We understand that circumstances may arise that prevent you from keeping your appointment. Please remember to be courteous to us and the other patients by calling at least **24 hours prior** to your appointment time to **cancel or reschedule**. Patients arriving late, after their appointment time, or without their copay will be considered as a "missed appointment," will be required to reschedule and will be charged a rescheduling fee. Every effort will be made to reschedule your appointment promptly, even same day if available.

- **First Missed Appointment:** A $25.00 fee will be assessed for your first missed appointment without at least a 24-hour advanced notice.
- **Second Missed Appointment:** A $25.00 fee will be assessed for your second missed appointment without at least a 24-hour advanced notice. Also, be aware that your prescription refills may be in jeopardy due to new regulations by **the state and the CDC** that you are evaluated by your provider on a regular basis for this service.
- **Third Missed Appointment:** A $50.00 fee will be assessed for your third missed appointment without at least a 24-hour advanced notice.
- **All missed appointment fees must be paid in full prior to seeing any physician and/or mid-level provider. Medication refills will not be provided following a missed appointment until you have been seen in the office for re-evaluation.**
- **Missed referral appointment:** This will be counted as a "missed appointment" and you may or may not receive any more referral appointments through **Synergy Healthcare Solutions.**
- If you do not have a driver for a scheduled procedure, your appointment will be canceled, and a $50.00 rescheduling fee will be charged which must be paid prior to any future appointment.
- **All "missed appointments" for minor procedures or pain pump refills** without at least a 24-hour advanced notice will be charged $50.00.
- **All "missed appointments" for Vertebroplasty/Kyphoplasty, Spinal Cord Stimulator Trial or Implant, Pain Pump Trial or Implant surgeries will be charged $150.**
- **Two (2) consecutively missed appointments with Synergy Healthcare Solutions, P.T., O.T., Psychotherapy, Group work, etc. may lead to discharge from the service and possibly the Synergy practice.**

Missed appointments cost us all time, effort, and money. If you have any questions, please ask any of the staff or your Physician/Nurse Practitioner.

May 2018

Guidelines for Patient Prescription Refills

Synergy Healthcare Solutions consist of multiple providers that, amongst other therapies, write a variety of medication prescriptions to help their patients control pain. Synergy Healthcare Solutions strives to provide all patients with their needed prescriptions on time and asks that you follow the guidelines below to help us provide your requested prescriptions in a timely manner.

- Please call your pharmacy or our office for medication refill requests at least **five (5) business days** (excluding weekend days or holidays) prior to the date your supply will be depleted.

- Most ideally, you will obtain your prescription(s) from your provider at your appointment. If you are 7-10 days from your refill date, ask your provider for a "Do Not Fill Date" on your prescription. If you miss your appointment, it is up to you to reschedule your appointment and cover your refill needs at the rescheduled appointment.

- If you are going to be out of town for an extended period of time, and your refill date falls in that time frame., please call at least 5 business days prior to leaving town for a refill.

- In months you are not scheduled to see your provider, you will be able to pick up your prescription(s) at a designated opioid encounter. If you are unable to keep your opioid appointment, you must call at least 24 hours in advance to cancel. Missing these appointments are subject to Synergy's "missed appointment policy" and may result in discontinuation or lapses in access to your medications.

- Prescriptions for controlled substances cannot be faxed or electronically prescribed. Prescriptions will only be mailed to pharmacies (mail order pharmacies included) at the provider's discretion. NO prescriptions will be mailed to private residences. Due to variations in the postal service delivery times, when making a refill request allow enough time to process and mail the prescription. A $5.00 fee is charged for all mailed prescriptions.

- **Patients presenting to any Synergy Healthcare Solutions location (main office, clinic or remote location) without an appointment will not be able to obtain a prescription. A scheduled appointment or encounter is required.** Except in extenuating circumstances and with prior permission (including a current HIPAA waiver and authentic, valid photo ID), prescriptions WILL NOT be released to individuals other than that for whom the prescription is intended.

- Once a prescription is dispensed to you, it is your responsibility to keep that prescription and the filled medication safe and accounted for as it has been entrusted to you.

- Lost or stolen prescriptions or medications will not be replaced. Lost, stolen or otherwise missing controlled prescriptions or medications may result in permanent discontinuation of all controlled medications.

Consent for Chronic Therapy with Controlled Substances

I understand that my provider at Synergy Healthcare Solutions (Synergy) is recommending a controlled substance, including but not limited to opioid analgesics, to help manage my pain. I agree that I, of my own free will, have sought care from Synergy in order to better manage my pain and that multiple treatment options, including Physical Therapy, Occupational Therapy, Chiropractic, non-opioid analgesics, injections/interventions, etc. have been recommended, prescribed or otherwise made available to me by my provider(s) at Synergy. I further recognize that these therapies have been, are currently and will be continuously available to me throughout my treatment with these medications. I agree that it is in my best interest to utilize a combination of multiple treatment options, as medically appropriate, to optimally control my pain and physical functioning in order to limit requirements for opioid analgesics and therefore minimize my dose.

I understand that these medications are being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my provider about all other medicines and treatments that I am receiving – and I agree that I will promptly advise my provider if I start to take any new medications or start any new treatments. Likewise, I have told my provider about my complete personal drug history and that of my family, including any personal or family history of past substance use, abuse or addiction, and agree to cooperate fully, honestly and in good faith with all efforts to evaluate, monitor and reduce risk (drug testing, questionnaires/assessments, counseling and psychological therapies, etc. as deemed appropriate by my provider).

I have been informed by my provider that the initiation of any medication, including controlled substances, is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by degree of pain relief, functional improvement, presence or absence of side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations regarding use or effect that may arise may lead my provider to discontinue this treatment or to change dosage, completely at their discretion.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles (possibly resulting in ticketing or arrest for DUI or automobile accident with life threatening injury).
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain relieving properties of the medication.
- Withdrawal (this means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience symptoms of including but not limited to runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
- Addiction
- Failure to provide pain relief

- Changes in sexual function (this is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
- Other changes in hormone levels with potential for long-term negative health effects
- Other poorly or as of yet not understood effects on lifestyle, mood or health with long-term use

In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequences on a child's development following exposure to opioids is not fully understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the controlled medication.

I would note that I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I will not combine the use of these medications with alcohol, or with other sedatives including muscle relaxants or sleeping pills without the explicit knowledge and permission of my provider. I understand that unauthorized changes may result in my running out of medications early, and early refills may not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting, diarrhea, palpitations and general discomfort.

I have been advised by my physician that certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. I understand that taking any of these other medicines while I am taking my pain medicines can cause moderate to severe flu-like symptoms, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other providers that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I will obtain all opioids prescriptions from my provider or, during his or her absence, by the covering provider. Requests for pain medications from the on-call providers (nights, weekends, holidays) will not be honored. I will not request medications outside of normal business hours. I will notify, and obtain permission from, my provider prior to starting any pain medications, including opioids, from any other provider for any reason.

I will obtain all scheduled medications from one pharmacy. I will notify my physician if I change pharmacies.

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

I will submit to random pill counts and urine, saliva and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances or absence of my prescribed medications in my urine, saliva or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only period. I understand that it is illegal to trade, sell or otherwise divert controlled medications and can result in dismissal from the practice as well as legal consequences.

I will always effectively and adequately protect any prescription or medication I receive through a Synergy provider. I will not share, sell or otherwise permit others to have access to these medications, nor will I obtain access to anyone else's prescription medications, opioid analgesics or other controlled substances.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT, IN ITS ENTIRETY. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH CONTROLLED SUBSTANCES, INCLUDING OPIOID PAIN MEDICINES.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient's signature:____ Date: ________________

Witnessed by:____ Date: ________________

Patient-Physician Agreement for Pain Management and Controlled Medications

Pain management is a broad specialty and treatment programs to better manage chronic pain may include diagnostic and/or therapeutic interventions, behavioral or psychiatric medicine, alternative therapies, regenerative techniques, implantable devices, physical therapy, chiropractic therapies, weight management and/or the prescribing of pain medications to include controlled substances such as opioid analgesics.

As with many medical therapies, there are real risks associated with chronic use of controlled substances. Use of these medications designated by the government as "controlled," also carry with them a specific set of legal requirements, restrictions and consequences for violation of these restrictions. These unique issues require careful attention and management. Connotations and risks associated with opioid pain medications and the need for effective, safe pain management can lead to unique tensions between patients and their caregivers.

The purpose of this document ("Agreement") is to establish a set of clear rules and requirements governing patient access to pain treatment and medications, especially controlled medications such as opioids or benzodiazepines, through your treating provider at Synergy Healthcare Solutions, LLC ("Synergy"). This process is common to most medical practices, is recommended if not legally required by many governing organizations and is undertaken in order to maximize patient safety and satisfaction by limiting medication errors or abuse and by detailing the risks of and preventing misunderstandings about certain medications that you may be prescribed for the management of your pain.

This agreement is an essential factor in maintaining the trust, confidence and mutual respect necessary for an effective provider/patient relationship as well as to help both you and your provider comply with the laws regarding controlled pharmaceuticals.

- I understand that strict adherence to this agreement is essential to the trust and confidence necessary to maintain a provider/patient relationship and that at no point does the requirement to read and sign this agreement indicate a lack of trust in me by my provider.

- I understand that if I violate this Agreement I have effectively and irreparably damaged the patient/provider relationship and, as a result, my provider will stop prescribing pain medications and may elect to dismiss me from the practice at the discretion of the provider and the approval of the Medical Director.

- I understand that the providers, clinic and office staff are to be treated at all times with respect whether in person, by written communication or by telephone. Rudeness, belligerence, damage to property, theft, improper language, violent, illegal or unethical behavior, threats of physical harm or litigation or any disruptive or inappropriate behavior by myself or anyone who accompanies me to my appointments or interacts with the clinic on my behalf will be grounds for immediate termination from the practice.

- I understand that I may not necessarily and should not expect to be prescribed any medication on my first visit or any subsequent visit, or until a urine, blood or saliva drug screen and confirmation test has been performed and results received. I understand that my provider has specialized training and experience in the effective management of these medications as well as risk reduction and avoidance. As a result, I agree to follow their recommendations and will not attempt to negotiate or in any way manipulate the provider in an effort to maintain or increase access to opioid analgesics.

- I will communicate fully, openly and truthfully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, how well the medications are helping to relieve the pain, the presence of any unintended effects or complications as well as my full medical, surgical and family history. I will completely, truthfully, and willingly participate in any effort to assess my pain, physical functioning and quality of life, including interview, physical examination and the timely completion of questionnaires, assessments, psychological, medical and diagnostic testing and specialty referrals.

- I will remain under the routine care of a primary care practitioner at all times. I will agree to allow my provider(s) at Synergy full access to my complete medical history and record, including past history and exposures to controlled substances, psychological assessment and treatments as well as testing or treatments surrounding substance abuse or chemical dependency), and to provide this information when requested.

- I will participate fully and consistently with all recommendations made by my provider, including full participation in physical therapy modalities, chiropractic evaluation and treatment, interventional therapies, specialty referrals or therapies, substance abuse counseling, behavioral assessments and therapies, diagnostic testing, non-narcotic medications, as well as any medication weans, rotations and adjustments.

- I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction, respiratory depression, confusion, sedation, coma and death. Overdose of opioid medication or combination with other sedating medications, accidental or intentional, may cause injury or death.

- I realize it is my responsibility to keep others and myself safe from harm. This includes protecting my medications from loss, accidental misuse or diversion, or from inadvertent access or consumption by unintended individuals. Failure to do so may result in discontinuation of any or all medications prescribed by a Synergy provider. It also includes safe driving and the safe operation of machinery while on medication. I understand that use of any prescribed medication could negatively impact my ability to safely perform these activities. If there is any question of impairment in my ability to safely perform any activity, I will not attempt to perform that activity and will notify my provider.

- I understand that I could develop a physical dependence within a short period after starting opioid therapy. If I suddenly stop or decrease the medication or start medications that interfere with the function of my opioid medications, I could have withdrawal symptoms. Withdrawal from medications can have serious consequences, including the risks of illness, injury or death. I will not discontinue my medications, change the dosing of my medications, or start new medications, without consulting my Synergy Healthcare Solutions Provider.

- I understand that if I am pregnant or become pregnant while taking medications, my unborn child could be born dependent on these opioids. I understand that we do not fully know the potential effects this exposure could have on the long-term development of a child. I will notify my provider immediately if I think I am pregnant or am considering becoming pregnant.

- I understand that using illegal controlled substances, including the use of unregistered cannabis (marijuana, THC) or even registered cannabis without my provider's consent, will be grounds for discontinuation of opioids and/or immediate termination from the practice. I understand that I cannot combine the use of these medications with alcohol at any time. I understand that the combined use of opioid analgesics and other sedating medications such as tranquilizers (e.g. Valium™, Xanax™, Ativan™), muscle relaxants, sleeping medications (e.g. Ambien™) can increase the risk of sedation, physical and cognitive impairment, respiratory depression, overdose and death. I agree to notify my Synergy provider, as well as all of my prescribing physicians that I am on chronic opioid therapy and that it is not recommended to use these medications in combination. Patients may be required (See next page)

(continued) to discontinue use of benzodiazepines for safety due to the measurably increased risk of death when combined with narcotics.

- I will not share, sell or trade my medications with anyone, including my family or spouse, nor will I use medications that have not been prescribed for me.
- I will not attempt to obtain any controlled medications, including opioid pain medications, controlled sedatives or stimulants from any other provider. I will consult with my Synergy provider and obtain their consent prior to filling or initiating any outside prescriptions for pain medicine.
- I will safeguard my pain medications from loss or theft. Lost/stolen medications or prescriptions will not be replaced.
- I am responsible for keeping all of my scheduled appointments, which includes opioid encounter appointments. I will arrive for my appointment on time. I will willingly comply with all paperwork requested and will arrive with enough time to complete the required paperwork prior to my appointment time. I understand if I arrive after my appointment time, the appointment will be rescheduled and I will be charged a rescheduling fee (as per the current Synergy "Missed Appointment Policy" which may be changed at Synergy's sole discretion without notice, from time to time). I agree to meet my financial obligations to the clinic in a timely manner and understand that failure to meet these obligations could result in delays in my care or dismissal from the practice.
- I understand at my provider's discretion I may be called for random drug tests or pill counts. If you do not come in within the allotted time, opioid medications will be discontinued.
- Prescription renewals are contingent upon keeping each scheduled appointment. If I do not cancel my appointment within 24 hours, arrive late to an appointment, show up to my appointment without my copayment or if a driver is not present for a procedure my visit may be rescheduled and subject to Synergy's 'missed appointment policy."
- I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. A request for medication refills must be made at least five business days prior to pick up. No refills will be available during evenings, weekends and/or holidays.

I agree to use_______________________________________Pharmacy, located at
____, telephone

number___________________________________, for filling prescriptions for all of my pain medications. I also agree to notify my physician or representative immediately if my Pharmacy selection changes.

- I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medications. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to pill counts and/or blood, saliva or urine testing if requested by my provider to determine my compliance with dosing recommendations and restrictions. I agree to bring in all of my

medications to each visit and understand that a pill count or drug screen may be performed on a random basis. All requests for drug testing or pill counts must be completed prior to the end of the visit. If I am called in to the office outside of a scheduled office visit, I have no more than 24 hours to present with ALL of my medications for the requested pill count or testing.

- I agree that I will use my medications at a rate no greater than the prescribed rate and that use of my medications at a greater rate will result in my being without medication for a period of time and jeopardize future prescription refill requests. I will not attempt to get pain medication from any other health care provider without informing them that I am already receiving pain medications from Synergy and have signed a pain management agreement.

- I agree to comply with all treatment modalities as part of my pain management plan of care prescribed and/or referred by my provider. This may include DNA testing, urine drug tests, provider requested pill counts or other tests my provider deems necessary. Further, I understand failure to comply with all treatment modalities i.e., two (2) consecutively missed appointments with Synergy Healthcare Solutions P.T., O.T., Psychotherapy, Group work, etc. may lead to my discharge from the Synergy Healthcare Solutions practice.

- I agree to follow these guidelines as outlined above. I am aware I have the opportunity to ask clarifying questions at any time during treatment. I agree that I am responsible for compliance with this Pain Management Agreement.

I have thoroughly read, understand and accept all of the provisions in the Financial Agreement, Missed Appointment Policy, Patient Prescription Refill Guidelines, Consent for Chronic Therapy with Controlled Substances and Patient-Physician Agreement for Pain Management and Controlled Medications. Any questions I had regarding these policies, and specifically this agreement, have been answered to my satisfaction. I fully understand and intend to comply with all policies regarding the prescribing and use of opioids and other medications, and willingly agree to accept any of the above consequences in the event of my failure to comply, whether or not I perceive this failure to be accidental, purposeful or as a result of a claimed lack of knowledge of the terms represented within these documents.

I authorize Synergy Healthcare Solutions to administer treatment, order and perform diagnostic testing and perform procedures as deemed necessary or advisable in my care. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Synergy Healthcare Solutions. In the event that my insurance carrier does not cover payment for services rendered, for whatever reason, I agree to take full personal responsibility for payment. I give Synergy Healthcare Solutions permission to appeal any denials by my insurance for services rendered on my behalf.

I understand the above are legal documents subject to judicial review and enforcement.

This Agreement is entered on this________day of__________________, 20_________.

Patient's signature: ____

Witnessed by:____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_______________________________________ **Date of Birth:** ___________**Phone:** __________________________

Retrieve Medical records from:____

Address, City, State Zip: ____

Phone Number:____________________________________ **Fax Number**:____

Above listed patient authorizes the requested healthcare facility to make record disclosure from (date) ___/____/____ to ___/____/____. If left blank, only information from the past year from the date of request will be disclosed.

Please release records to:

Synergy Healthcare Solutions **Phone: 618-288-6722**
2023 Vadalabene Dr., Suite 300 Maryville, IL 62062 **Fax: 618-288-2077**

Please release the following:

☐ Progress notes ☐ Lab results ☐ Imaging films ☐ Imaging reports
☐ Itemized billing ☐ Any and all records ☐ Other: ____________________

Please release records in the following format:

☐ Paper - copying fees may apply ☐ Encrypted email: ____
☐ CD - fee may apply

The purpose of disclosure is:

☐ Personal use ☐ Change of Insurance ☐ Referral ☐ Continuation of Care (e.g., VA Med Ctr) ☐ Other___________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information included in the specified range of dates above. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse and DNA testing. If you DO NOT want certain portions of your medical records released, identify the information you DO NOT want released:____

This information may be disclosed and used by the following individual or organization:____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _________________.**

If I fail to specify an expiration date, event, or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X____
Signature of Patient / Parent / Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status.)

____
Printed name of Authorized Representative Relationship / Capacity to patient

____
Address and telephone number of authorized representative
Office use only: Intake personnel:____________________ Processed by :______________________Date processed:_____________________