Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Our Commitment to You

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.
- If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that your keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- We are sorry, but due to the high fax volume we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    1. Photo ID
    2. MRI films and reports, CT scan films and reports and/or bone scan reports
    3. EMG reports
    4. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
    5. List of current medications

Financial Policy

- We are committed to providing you with the best possible care.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.
- Returned cheks will be subject to **an additional $25 service fee**.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.

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- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.

I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for this account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

____________________________________ X ____________________________ __________

Patient Name Signature Date

Regenerative Medicine Therapy (PRP and Stem Cell Therapy) Disclaimer

I wish to participate in Regenerative Medicine Therapy (PRP and Stem Cell Therapy) at Relievus. I understand and acknowledge that Regenerative Medicine Therapy (PRP and Stem Cell Therapy) is **NOT** covered by either federal or private payors and that my personal healthcare insurance does **NOT** cover Regenerative Medicine Therapy. Thus, I agree not to make a claim for Regenerative Medicine Therapy (PRP and Stem Cell Therapy) with my personal healthcare insurance carrier and further agree and acknowledge that I must pay by cash or major credit card all related healthcare costs related to Regenerative Medicine Therapy (PRP and Stem Cell Therapy) at Relievus.

By signing below, I accept and acknowledge that **I am opting out** of using my healthcare insurance for Regenerative Medicine Therapy (PRP and Stem Cell Therapy) and accept paying cash or major credit card for these services.

I understand clearly that Regenerative Medicine including PRP (Platelet Rich Plasma) and Stem Cell injection therapy is NOT FDA approved.

Acknowledged and accepted by:

____

Patient Name

____

Patient Signature Date

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Patient Registration Form

Personal Information			
Name		Date of Birth	
Home Address		Age	
		Sex	
		SS#	
Home phone #		Driver's license #	
Mobile #		Marital status	
Referred by		Pharmacy Name	
Primary physician		Pharmacy phone #	
Employment information			
Employed by		Occupation	
Address		Phone #	
Spouse Information / Guardian's Information if Under Age 18			
Spouse's name		Spouse's occupation	
Spouse's phone #		Spouse employed by	
Emergency contact			
Name		Phone #	
Address		Relationship	
Primary Insurance			
Name of Insurance		Primary Holder	
Address		Policy #	
Subscriber's Birthdate		Group name or #	
Secondary Insurance			
Name of Insurance co		Primary Holder	
Address		Policy #	
Subscriber's Birthdate		Group name or #	

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

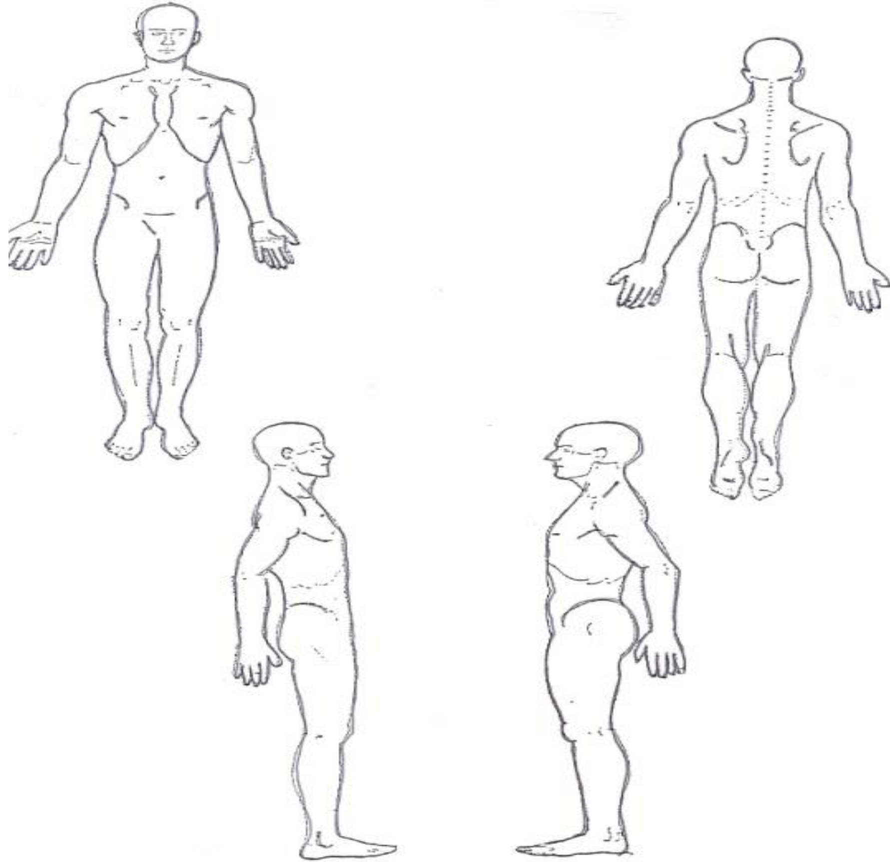
• Today's date: _____________ • Name : ____

• Age___________ • Date of Birth ____________________ • Height __________ • Weight ___________

□ Right hand dominant □ Left hand dominant • Sex : □ Male □ Female

Referred by: ______________________

Chief Complaints;



• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

• Location ____

____

____

• Does the pain radiate anywhere ("shooting down" or "shooting up")

____

• When was the pain started ? ____

____

• How was the pain started ? ____

____

• Please, describe your pain

☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Numbness ☐ Burning

____

• How often is your pain present ? ☐ Occasional ☐ Frequent ☐ Constant

• Worst time of day? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time

• Any color change or temperature change? ______________________________

• Numbness in anywhere? ____

• "Pins and needles" ? ____

• Weakness? (Right leg, right arm, both legs….) ___________________________

• Swelling ? ____

• What makes symptoms worse/exacerbate? ____________________________

☐ Walking ☐ Standing ☐ Lying down ☐ Sitting ☐ Bending forward ☐ Bending backward ☐ Driving

☐ Coughing ☐ Bowel movement ☐ Cold weather ☐ Hot weather ☐ Rainy day ☐ Lifting objects

• What makes the symptoms better ? ____

☐ Resting ☐ Massage ☐ Exercise ☐ Sitting ☐ Lying down ☐ TENS unit ☐ Physical therapy

☐ "Injections" ☐ Sleeping ☐ Medication (Names) __________________ ☐ Other __________________

• Sleeping : ☐ Well ☐ "OK" ☐ Terrible ☐ 2 hrs ☐ 4 hrs ☐ 6 hrs ☐ 8 hrs ☐ >10 hrs

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

- How often do you wake up at night? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >5 times

Previous Treatments

Physical therapy ☐ Location ________________________ ☐ Date of Last PT _______________ ☐ Duration _______________

Acupuncture ________________________ Psychotherapy ____________________________

Chiropractor _____________________ Other (Biofeedback, Meditation, Yoga, Swimming)

TENS Unit ☐ Never used ☐ I have a unit ☐ I don't have one ☐ Used at home daily ☐ Used at home as needed ☐ Used during PT

Review of System

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐Weakness ☐Stroke ☐ Tremor ☐ Seizure ☐ Memory loss
- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT ☐ Ear pain ☐Hearing loss ☐Ear noises ☐Nose bleed ☐Sore throat ☐Hoarseness ☐Dental issues
- Cardiovascula ☐ Chest pain ☐Chest pressure ☐Shortness of breath ☐Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood
- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐Heartburn ☐Bloody stool ☐Pain in stomach ☐Ulcers ☐Hepatitis
- Genitourinary☐ Painful urination ☐Frequent urination ☐Bloody urine ☐Kidney stone ☐Incontinence
  ☐ Sexual difficulty ☐ Infection
- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐ Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐ Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐Rheumatoid arthritis ☐Osteoarthritis ☐Compression fracture ☐Head injury
  ☐ Neck injury☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus
  ☐ Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis
- Women only ☐ Irregular periods ☐ Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps
  ☐ Vaginal discharge ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram ___________
- Men only ☐ Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty urinating
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts
  ☐ Suicidal ideation ☐ Homicidal ☐ Hallucination ☐ Psychosis ☐ Other ________________

Past Medical History

- Heart ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐ Valvular disease ☐ Aneurysm ☐ High cholesterol
  ☐ Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other _______________
- Lungs ☐ Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other _________
- Gastrointestinal ☐ Ulcer ☐ Reflux ☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other _____________
- Kidney ☐ Failure ☐ Stones ☐ Dialysis (When) _____________ ☐ Other ________________
- Endocrine ☐ Diabetes ☐ Hypothyrodism ☐ Hyperthyroidism ☐ Other _______________
- Neuro ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia
  ☐ Seizures ☐ Parkinson's ☐ Other __________
- Psychiatric ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other ___________
- Bone/Muscular ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other _________
- Cancer ☐ ____

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

• Other ☐ ____

Past Surgery History

____

____

Allergies

• Latex ☐ No ☐ Yes Reaction ______________ • Contrast (Dye) ☐ No ☐ Yes Reaction _________

• Allergic to any medication(s) ? ____

____

Previous Medications (Tried previously but failed to relieve the symptoms & pain)

____

____

Current Medications

____

____

____

Significant Family History (Cancer, hypertension, diabetes, depression, back pain…)

- Father side ____
- Mother side ____
- Siblings ____

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Social History

- Tobacco: ◻ Never ◻ Quit in _______ ◻ Currently ____ pack per day
- Alcohol : ◻ Never ◻ Rarely ◻ Moderate ◻ Daily_______________
- Use of drugs: ◻ Never ◻ Occasionally ◻ Frequently, Type/frequency ____________
- Marital status: ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed
- Family status: Living with ____
- Occupation: ____
- Disability: ◻ No ◻ Yes (Type) _____________________

I understand clearly that Regenerative Medicine including PRP (Platelet Rich Plasma) and Stem Cell injection therapy is NOT FDA approved.

This form is completed by

◻ Patient X ____________________________________ Date _____________

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Authorization for Release of Information

Name of Patient _________________________________ Date of Birth ________________

Relievus is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Description of information to be released
Check each person/entity that you approve to receive information.

- Voice Mail
  ☐ Results of lab tests/x-rays
  ☐ Other____
- Spouse (provide name & phone number)_______________________________________
  ☐ Financial
  ☐ Medical as follows:____
- Parent (provide name & phone number) _______________________________________
  ☐ Financial
  ☐ Medical as follows:____
- Other (provide name & phone number) ____
  ☐ Financial
  ☐ Medical as follows:____

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

____ Date ______________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care service. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our web site www.relievus.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when have the necessary permission from you to disclose your protected health information. For example, your protected health information is provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician.
Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and Disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your physician may, using professorial judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on out professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situation without your authorization. These situations include:
Required By Law: We may use or disclose your protected health information to the extent that use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such or disclosures.
Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose protected health information to a health oversight agency got activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit program, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state law.
Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviation, tract products; to enable product recalls; to make repairs replacements, or to conduct post marketing surveillance as required.
Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purpose include (1) legal processes and otherwise required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises or the practice, and (6) medical emergency (not on practice's premises) and it's likely that a crime has occurred.
Coroners, Funeral Directors, and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to reasonable anticipation of death. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purpose.
Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Criminal Activity: Consistent with applicable federal and state law, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual.
Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
Required Uses and Disclosure: Under the law, we must make disclosure to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Your Rights

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have the decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. **You have the right to request a restriction of your protected health information.** This means you may ask us not or disclose any part of your protected health information for the purpose of treatment, payment or health operation. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by (**describe how patient may obtain a restriction.)**
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purpose. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain; restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name ____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature ____Date _________________________

Cherry Hill 1400 Route 70 East, Cherry Hill NJ 08034
(888) 985 -2727 www. Relieves.com Fax (609) 567-8832

Regenerative Medicine Therapy (PRP and Stem Cell Therapy)

Opioid (Narcotic) Treatment Agreement

I understand that in order to receive care for the treatment of pain in Relievus - Advanced Spine And Pain, LLC, I **MUST** comply with the following rules:

1. I **UNDERSTAND** that narcotic and controlled drug prescriptions are **MY RESPONSIBILITY** once they are placed in my hand. I **UNDERSTAND** that if anything happens to this prescription (i.e. it is lost, stolen, flushed down the toilet, etc.), I am personally responsible, and physicians, physician's assistants and/or nurse practitioners **WILL NOT** rewrite the prescription until the designated time is given.
2. Your narcotic and controlled drug prescription **WILL NEVER** be refilled after hours or on the weekends.
3. All controlled substances should be obtained at the **SAME PHARMACY**. Should the need arise to change pharmacies our office must be informed.
4. I **WILL** take medications as a dose and frequency prescribed. Any changes in the dose or frequency will be discussed with my physician, physician's assistant and/or nurse practitioner at Relievus - Advanced Spine And Pain, LLC. If my medications are prescribed every eight-hour basis, I **WILL** take these medications every eight hours. I **UNDERSTAND** that if I use more than the allowed amount or use up my medication before my appointment date, **NO MORE PILLS WILL BE GIVEN**.
5. I **UNDERSTAND** that narcotics and controlled drug prescriptions **WILL NOT** be phoned into the pharmacy. I **MUST** appear for my given appointment time.
6. I **UNDERSTAND** that if I come in at an earlier date for an appointment, my medication **WILL NOT** be given the date of the original appointment.
7. I **WILL** receive prescriptions at the interval determined by physician, physician's assistant and/or nurse practitioner in Relievus - Advanced Spine And Pain, LLC.
8. I **WILL NOT** receive controlled substances for the treatment of pain from any source other physician, physician's assistant and/or nurse practitioner in Relievus - Advanced Spine And Pain, LLC.
9. I **WILL** communicate with my primary physician that I am treated at Relievus - Advanced Spine And Pain (ASAP) for the controlled prescribing of pain medications. I understand that Relievus - Advanced Spine And Pain (ASAP) has the permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide your health care.
10. I **WILL** consent to random drug testing. I will **NOT** use **any illegal substances** (cocaine, heroin, crystal methamphetamine, PCP, ectasy, ketamine, etc.) or use any controlled substances which are not prescribed in our practice while being treated with controlled substances at Relievus. Refusal of such testing or positive results will result in prompt termination of care from Relievus - Advanced Pain And Spine (ASAP).
11. I **WILL** safeguard my prescribed medications. I understand that these medications may be lethal or hazardous to a person that is not tolerant to its affects, especially a child.
12. I **WILL** comply with my schedule appointments.
13. I **UNDERSTAND** that there is a possibility of impairment of thought processes, especially if this narcotic is combined with a sedative, a sleeping pill, tranquilizer or alcohol.
14. I **UNDERSTAND** the possible adverse effects and dependencies associated with these medications. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing, sexual dysfunction, and or depressed respiration.
15. I **UNDERSTAND** that if I plan to become pregnant or become pregnant, I have to inform physician, physician's assistant and/or nurse practitioner in Relievus - Advanced Spine And Pain, LLC immediately. I **UNDERSTAND** that if I become pregnant, a child **WILL** likely be physically dependent at birth if I continue narcotics.
16. You are expected to **INFORM OUR OFFICE** of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
17. I **UNDERSTAND** that changing date, quantity or strength of medication or altering a prescription in any way, shape or form is against the law. Forged signatures are also against the law. If there is a violation this will be reported to the patient's pharmacy, local authorities and DEA.
18. I realize that it is **MY RESPONSIBILITY** to keep others and myself from harm, including safety of driving and the operation of machinery.
19. I **UNDERSTAND** that if I violate this contract, all medications from Relievus - Advanced Spine And Pain (ASAP) **WILL** thereafter CEASE.
20. I **UNDERSTAND** this mode of treatment will be stopped if any of the following occurs:
    a) I giveaway, sell, or misuse the drugs or use other people's drugs or illegal substances
    b) I am noncompliant with any of the terms of this agreement
    c) I disrespect or harass any of the Relievus - Advanced Spine And Pain (ASAP) personnel.
    d) I do not follow up regularly or as requested by my physician, physician's assistant and/or nurse practitioner.

YOU ARE INFORMED that you have the right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

____ ________________

Patient's name / Signature Date

Cherry Hill 1400 Route 70 East, Cherry Hill NJ 08034

(888) 985 -2727 www. Relieves.com Fax (609) 567-8832