PAIN & ARTHRITIS CENTER, P.C.

Date: _____ Do you have Medicare? Yes or No Are you Disabled? Yes or No Male or Female

Patient Name: _____

Last MI First

Physical Address: _____

Mailing Address if different than above: _____

Home Phone: _____ Cell Phone: _____ Work Number: _____

Primary Care Doctor: _____ Primary Doctor Office Number: _____

Referring Doctor: _____ Referring Doctor Office Number: _____

Patient Date of Birth: _____ Social Security Number: _____

Marital Status: Married Single Separated Widowed Partner

Spouse's Name: _____

Emergency Contact & Relationship: _____

Emergency Contact Phone Number(s): _____

_____

Primary Insurance Coverage: _____

ID Number: _____ Group Number: _____

Employer: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number: _____

Policy Holder Address: _____ Phone Number: _____

_____

Secondary Coverage: _____

ID Number: _____ Group Number: _____

Employer: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number: _____

Policy Holder Address: _____ Phone Number: _____

By signing this form you are stating the above information is true and accurate to be best of your knowledge, failure to provide all accurate insurance information could result in a denial of claims being paid by your insurance company and could result in the charges being billed to you the patient/guarantor for payment.

_____ _____ ___/___/___

Print your name Sign your name Date

Pain & Arthritis Center, P.C.

6120 Brandon Avenue, Suite 201
Springfield, VA 22150
Telephone: 703-923-9536
Fax: 703-923-9537

2124 Richmond Highway, Suite 101
Stafford, VA 22554
Telephone: 703-923-9536
Fax: 540-318-6259

Financial Policy

1. Pain and Arthritis Center participates with most insurance carriers. As a courtesy we will contact your insurance carrier to confirm coverage and file your claims for you.
2. Co-pays and deductibles are due at the time of service.
3. You are responsible for the percentage of the service cost that is not covered by your insurance, (i.e. Co-pays, deductibles and co-insurance).
4. Please be advised that if for any reason your insurance carrier fails to cover cost for services rendered, you will become the responsible party.
5. Should your account need to be referred to an outside collection agency, you will be responsible for a **33 percent collection fee**, which will be added to the outstanding balance.

General Policy

1. Primary Care Referrals – Please obtain appropriate referrals in advance of your visits. Unfortunately, patients cannot be seen without the appropriate referrals. Should, for some reason you are seen without a valid referral, you are accepting responsibility of the balance unless you obtain a valid referral on that day for the visit.
2. Should you need a copy of your medical record to give to another doctor you must have the office submit a request for records stating what they need from our office, because of the nature of our practice, patients will **NOT** be given a copy of their medical records.
3. Tardiness – Please call if you are running late. You may be asked to reschedule your appointment if you arrive 15 minutes late or more.
4. Cancellations – We ask that patients contact our office at least 24 business hours prior to their appointment time, if they need to cancel or reschedule. A fee of $50 will be assessed when the appropriate cancellation time is not given and payment is due before your next appointment.
5. Get your prescriptions and refills for all your medications at the time of your visit! If you do not, you may need to return for an appointment or your insurance **will be** billed a low level visit!

I have read this policy and I agree to the terms and conditions of the policy.

_____	_____	____/____/____
Print your name	Sign your name	Date
_____	_____	____/____/____
Witness name	Witness Signature	Date

Pain & Arthritis Center, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Pain & Arthritis Center's health care operations. The Notice of Privacy Practices also describes my rights and Pain & Arthritis Center's duties with respect to my protected health information. The Notice of Privacy Practices is available at our office and on our website at www.painandarthritiscenter.com.

Pain & Arthritis Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing Pain & Arthritis Center's website.

_____

Signature of Patient or Representative

_____

Name of Patient or Representative & Relationship

_____/____/_____

Date

I further (circle one) authorize/revoke authorization to have access to my records pertaining to billing and treatment to the following:

Name and relationship to patient: _____

Name and relationship to patient: _____

Name and relationship to patient: _____

Name and relationship to patient: _____

_____ ____/____/____

Office Witness Date

Pain & Arthritis Center, P.C.

6120 Brandon Avenue, Suite 201, Springfield, VA 22150
Phone: 703-923-9536 Fax: 703-923-9537

2124 Richmond Highway, Suite 101, Stafford, VA 22554
Phone: 703-923-9536 Fax: 540-318-6259

NOTICE OF PRIVACY PRACTICES

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

OUR COMMITMENT TO YOUR PRIVACY: Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). 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 purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. At **Pain & Arthritis Center, PC** the privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it.

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 calling the office and requesting that a revised copy be sent to you in the mail and asking for one at the time of your next appointment.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS: Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

The 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:

RIGHT TO RECEIVE CERTAIN ACCOUNTING DISCLOSURES: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. This request must be made in writing to our office and we will review your request and respond within 30 days.

RIGHT TO OBTAIN A PAPER COPY: You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office to have one mailed to you, ask for a copy at your next appointment or visit our web site at www.painandarthritiscenter.com.

OUR RESPONSIBILITIES: Pain & Arthritis Center, PC is required to:

- maintain the privacy of your health information
- notify you if we are unable to agree to a requested restriction
- abide by the terms of this notice
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

COMPLAINTS: If you have questions and would like additional information, you may contact our office at 703-923-9536. If you believe your privacy rights have been violated, you can file a complaint with our office in writing. There will be no retaliation for filing a complaint.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

TREATMENT: For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this practice.

PAYMENT: For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

HEALTHCARE OPERATIONS: For example: Members of this office may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

BUSINESS ASSOCIATES: There are some services provided in our organization through contacts with business associates. Examples include: physician services in the emergency department, radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

APPOINTMENT REMINDERS: We may contact you by phone or leave a message on your home, work or cell phone or with family members as a reminder that you have an appointment scheduled for medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

NOTIFICATION: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

COMMUNICATION WITH FAMILY MEMBERS: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

DISCLOSURES REQUIRED BY LAW: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

WORKERS' COMPENSATION/HEALTH OVERSIGHT ACTIVITIES: Your Protected Health Information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally-established programs. We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION: We will use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written ***Authorization***. If you give us ***Authorization*** to use or disclose health information about you, you may revoke that ***Authorization*** in writing at any time. If you revoke the ***Authorization***, we will no longer use or disclose information about you for the reasons covered by your written ***Authorization***, but we cannot take back any uses or disclosures already made with your permission.

FOOD AND DRUG ADMINISTRATION (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

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MEDICAL QUESTIONNAIRE

Date: ____/____/_____

Your Name: _____ Date of Birth: ____/____/_____
First Last

Have you ever had Work Injuries? ☐ Yes ☐ No If Yes, When? _____

Which body part? _____

Is any of your chronic pain caused by an Auto Accident? ☐ Yes ☐ No If Yes, When?_____

What body parts? _____

Please describe the painful location(s). List one at a time (Example: neck, arm, back, leg, foot)

The location of your chronic pain _____

Average pain intensity (0/10 VAS-10/10 VAS scale) _____ Worst pain intensity (0/10 VAS-10/10 VAS scale)_____

Starting Date of the chronic pain_____

Causes of the pain at this location_____

Nature of your chronic pain ☐ Constant ☐ Intermittent ☐ Dull ☐ Burning ☐ Stabbing ☐ Pulling ☐ Shooting ☐ Ache ☐ Other, please explain_____

Aggravating factors for the pain ☐ Sitting ☐ Laying ☐ Standing ☐ Walking ☐ Bending ☐ Twisting ☐ Driving ☐ Lifting ☐ Weather Changes ☐ Other, please explain_____

Reducing factors for the pain ☐ Sitting ☐ Standing ☐ Walking ☐ Laying ☐ Heat ☐ Cold ☐ Muscle Relaxant ☐ NSAIDS ☐ Physical Therapy ☐ Other, please explain_____

Treatment you have tried ☐ Physical Therapy ☐ Chiropractic Manipulation ☐ Acupuncture ☐ Narcotic Medication ☐ Anti-inflammatory Medication ☐ Epidural Injection ☐ Facet Joint Injection ☐ Facet Joint Nerve Denervation ☐ Sacroiliac Joint Injection ☐ Nerve Block ☐ Spinal Cord Stimulator ☐ Other Treatment, please explain_____

Benefit from the treatment_____

Image studies (such as: MRI, CT Scans, X-Rays, etc.)_____

PAST MEDICAL HISTORY

General: ☐ Insomnia ☐ Sleep Apnea ☐ Other, please explain _____

Mental Health: ☐ Depression ☐ Suicidal ☐ Anxiety ☐ Panic Attack ☐ Bipolar ☐ Psychosis
☐ Schizophrenia ☐ Other_____

Musculoskeletal: ☐ Osteoarthritis, in which joint(s) _____
☐ Cervical Spine Disc Disease ☐ Cervical Spine Arthrosis ☐ Cervical Spine Root Nerve Impingement
☐ Thoracic Spine Disc Disease ☐ Thoracic Spine Arthrosis ☐ Thoracic Spine Nerve Root Impingement
☐ Lumbar Disc Disease ☐ Lumbar Spine Arthrosis ☐ Lumbar Spine Nerve Root Impingement
☐ "Sciatica" ☐ Other_____

Rheumatology: ☐ Fibromyalgia ☐ Lupus ☐ Scleroderma ☐ Sjogren's Syndrome ☐ Gout ☐ Osteoarthritis
☐ Marfan's Syndrome ☐ Psoriatic Arthritis ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis
☐ Other, please explain_____

Neurology: ☐ Migraine ☐ Non-Migraine Headache ☐ Cluster Headache ☐ Peripheral Neuropathy ☐ TIA
☐ Brain Tumor ☐ Brain Aneurysm ☐ Carotid Artery Arthrosclerosis ☐ Seizure Disorder ☐ Stroke
☐ Multiple Sclerosis ☐ Head Trauma ☐ Other_____

Cardiology: ☐ CHF ☐ Pericarditis ☐ Hypertension ☐ Coronary Artery Disease
☐ Hyperlipidemia ☐ Angina Chest Pain ☐ Cardiac Arrhythmia ☐ Heart Valve Defect
☐ Blood Clots in Legs or Arms ☐ Pace Maker Placement ☐ Coronary Angiogram ☐ Coronary PTCA
☐ Other_____

Pulmonology: ☐ Asthma ☐ COPD ☐ Pneumonia ☐ Pulmonary Hypertension
☐ Pulmonary Embolism ☐ Idiopathic Pulmonary Fibrosis ☐ Pleuritis
☐ Other_____

Gastroenterology: ☐ IBS ☐ Gastric Ulcer ☐ GERD ☐ Hiatal Hernia ☐ Crohn's Disease ☐ Ulcerative Colitis
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Other

Hematology: ☐ Anemia ☐ Leukopenia ☐ Thrombocytopenia ☐ Coagulopathy

Endocrinology: ☐ Osteoporosis ☐ Diabetes ☐ Hypogonadism (low male hormone)
☐ Adrenal Gland Disease ☐ Hypothyroidism ☐ Parathyroid Disease ☐ Paget's Bone Disease
☐ *Other*_____

Nephrology: ☐ Kidney Stones ☐ Abnormal Kidney Function ☐ Frequent Urinary Tract Infection
☐ Bladder Problems (please specify)_____

Skin: ☐ Photo Sensitivity ☐ Psoriasis ☐ Rosacea ☐ Other_____

Infectious Disease: ☐ Lyme Disease ☐ HIV ☐ Tuberculosis ☐ Hepatitis B ☐ Hepatitis C
☐ Other_____

What medications worked for your chronic pain? _____

Which doctor currently prescribes your pain medications? _____

First Last

Medication Allergies? ☐ **No** ☐ **Yes** _____

Family History: List Major Illness Your Family Member Had _____

Social History: Your Occupation _____

Do you use tobacco? ☐ **No** ☐ **Yes If yes, how may packs per day?**_____

Do you have a history of heavy alcohol use? ☐ **No** ☐ **Yes**

PAST SURGICAL HISTORY

List all surgeries you have had in your life

Name of Surgery	Date	Surgeon's Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS

Name of Medication	Dose	Time of Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEM

General: ☐ Difficulty going to sleep ☐ Difficulty staying asleep ☐ Chronic Fatigue
☐ Other, please explain_____

Mental Health: ☐ Depression ☐ Suicidal ☐ Anxiety ☐ Panic Attack ☐ Irritable
☐ Other_____

Musculoskeletal: ☐ Pain in the back of the head ☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain
☐ Shoulder Pain ☐ Chest Wall Pain ☐ Rib Cage Pain ☐ Low Back Pain ☐ Buttock Pain ☐ Tail Bone Pain
☐ Hip Pain ☐ Thigh Pain ☐ Lower Leg Pain ☐ Knee Pain ☐ Ankle Pain ☐ Hand Pain ☐ Foot Pain
☐ Morning stiffness in hands and wrists ☐ Other_____

Rheumatology: ☐ Joint Swelling, which joint(s)?_____
☐ Frequent Oral Ulcers ☐ Double Jointed ☐ Psoriatic Skin Lesion ☐ Dry Mouth ☐ Dry Eyes
☐ Extreme Hair Loss ☐ Extreme Cold Fingers with Color Changes ☐ Painful Eyes with Inflammation
☐ Chronic Fever/Chills ☐ Facial Butterfly Rash ☐ Chronic Skin Rash
☐ Other_____

Neurology: ☐ Chronic Headache ☐ Chronic Burning Foot Pain ☐ Chronic Burning Leg Pain
☐ Chronic Arm Pain ☐ Chronic Leg Pain ☐ Limb Weakness ☐ Dizziness
☐ Other_____

Cardiology: ☐ Palpitation ☐ Chest Pain ☐ Other_____

Pulmonology: ☐ Shortness of Breath ☐ Dry Cough ☐ Productive Cough ☐ Blood in Sputum
☐ Other_____

Gastroenterology: ☐ Heart Burn ☐ Chronic Diarrhea ☐ Blood in Stool ☐ Constipation ☐ Fecal Incontinent
☐ Abdominal Pain, Please specify_____

Hematology: ☐ Easy Bruising ☐ Bleeding Problems ☐ Other_____

Endocrinology: ☐ Extreme Thirst ☐ Blurred Vision ☐ Always Cold ☐ Dry and Thin Hair
☐ Excessive Weight Gain for Unclear Reasons ☐ Other_____

Nephrology: ☐ Blood in Urine ☐ Urinary Frequency ☐ Urinary Incontinent ☐ Urinary Burning Sensation
☐ Difficulty Urinating ☐ Flank Pain ☐ Other_____

Skin: ☐ Sun Light Sensitivity ☐ Psoriasis ☐ Chronic Skin Break Down ☐ Other_____

Infectious Disease: ☐ Chronic Fever/Chill ☐ Other_____

Pain & Arthritis Center, P.C.

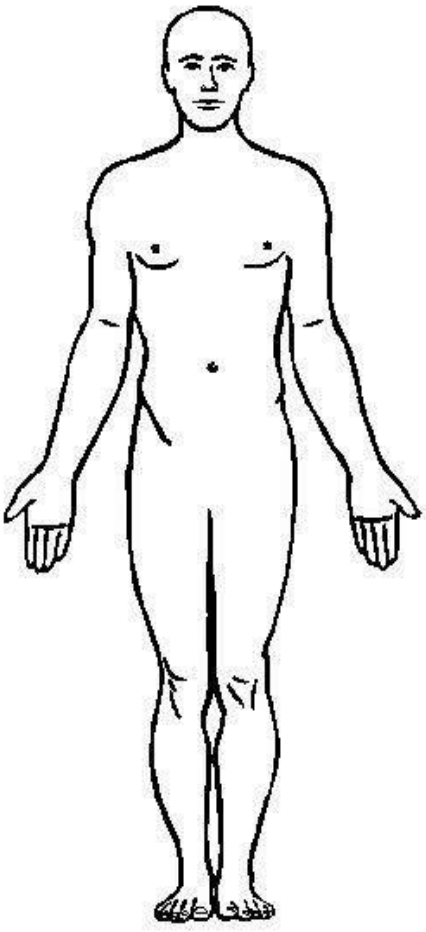
VISUAL ANALOG PAIN SCALE AND PATEINT UPDATE

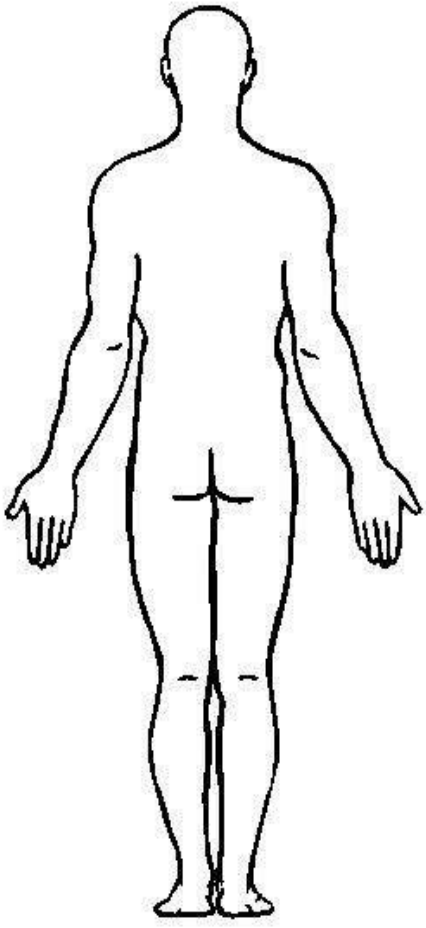
Patient Name: _____ Date: _____

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below. Write in any commentary that you think will be helpful to the doctor.

Since beginning treatment, what percentage improvement have you experienced? (Ex: I am 50% better) _____

KEY
///// Stabbing
XXXXX Burning
===== Numbness
+++++ Aching
PAIN LEVEL
0 to 10





0 – No Pain
1 – Mild Pain; you are aware of it but it doesn't bother you
2 – Moderate pain that you can tolerate without pain.
3 – Moderate pain that requires medication to tolerate.
4/5 – More severe pain; you begin to feel antisocial.
6 – Severe pain.
7/8/9 – Intensely severe pain.
10 – Most severe pain; it may make you contemplate suicide.

CIRCLE YOUR CURRET PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

Pain & Arthritis Center, P.C.

CONTRACT FOR NARCOTIC MEDICATION USAGE

1. I have agreed to use opioid medications as part of my pain management for a limited period.
2. I understand that the use of opioid medications has the risk for misuse, abuse, and addiction.
3. I **will not use any illegal** substances, such as heroin, marijuana, cocaine, etc.
4. I agree that the opioid medications are **strictly for my own use.** I will not share, sell or trade my opioid medications with others.
5. I certify that I will receive opioid medications and all other controlled substance medications **only from the physician at Pain & Arthritis Center.**
6. It is my responsibility to notify my physician if any side effects of the medications continue.
7. I agree to have my opioid medications filled **at a single pharmacy.**
8. I understand that **physical dependency** toward opioid medications is expected after long term use.
9. I agree to adhere strictly to medical instructions and laws governing the use of these medications and I will **not use illegal or alcohol** while I am on these medications.
10. I understand that I may be required to come to the clinic **weekly, every 2 weeks, every 3 weeks or monthly** at the start of my treatment or anytime during my treatment.
11. I agree to submit **urine and blood samples** for both prescribed and non-prescribed substances upon the request of the prescribing physician.
12. I agree to bring remaining prescribed opioid tablets to my physician for **"pill count" if requested** by the physician.
13. I agree that I will **not take more medication than prescribed** and will **not request early refills.**
14. **Lost, misplaced or stolen medications WILL NOT BE REPLACED.**
15. I understand that my physician has to make periodic assessment of my response to medications; I will therefore follow my physician's instruction and **return to the clinic every month.** Failure to follow up with my physician may result in discontinuation of opioid medication treatment and patient-physician relationship.
16. **Refill policy:** I understand that refills of narcotic medications will be made only during a regular office visit. **Refills will not be called in or mailed.** I agree to call my physician's office at least **3 business days in advance to request a refill** for non-narcotic prescriptions.
17. If it appears to the physician that there is no improvement to my daily function or quality of life from my opioid medications, the medications may be discontinued.
18. **Narcotic medication addiction is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows drug craving behavior or "doctor shopping", a manipulative attitude toward the physician in order to obtain the drug, or when the drug is quickly escalated without correlation to pain relief. If the patient exhibits such behavior, the drug will be discontinued, and the patient may be discharged.**

19. I understand that opioid medications may cause a **variety of side effects,** including, but not limited to nausea, vomiting, drowsiness, constipation, fluid retention and mental slowing, flushing, sweating, itching, weight changes, suppression of male hormone, suppression of thyroid function, suppression of menstrual cycle, suppression of immune system, jerkiness, and urinary difficulty.
20. I understand that these are potentially dangerous medications and that, if taken improperly, may lead to excess sedation, respiratory depression, and death.
21. I **authorize the release** of my information and records to my pain physician from my other health care providers, pharmacies, insurance companies, my family or employer.

FEMALE PATIENTS: You may not enter or continue the treatment program while pregnant!

1. **It is my responsibility to IMMEDIATELY notify the Pain & Arthritis Center that I am pregnant or if I become pregnant during my treatment.**
2. **I understand that my treatment will stop until after I have given birth or I am no longer pregnant. I MUST IMMEDIATELY find another detox doctor/clinic** and **OB/GYN** to treat myself and the baby during my pregnancy.
3. **I WILL BE RELEASED** from the clinic if I neglect to inform them of my pregnancy.
4. The Pain & Arthritis Center **is not liable** for any effects or death of a fetus/baby from improper or continued use of medications during pregnancy.

I certify that I have read and understand the above information and I hereby give my consent to participate in opioid medication therapy.

Patient Name: _____

Patient Signature: _____ **Date Signed: _____**

Pharmacy Name & Phone Number: _____

Physician Signature: _____, Cindy Y. Zhang, M.D.

PAIN & ARTHRITIS CENTER, P.C.

Cindy Y. Zhang, M.D., Ph.D.

6120 BRANDON AVENUE, SUITE 201
SPRINGFIELD, VA 22150
TELEPHONE: (703) 923-9536 FAX: (703) 923-9537

2124 RICHMOND HIGHWAY, SUITE 101
STAFFORD, VA 22554
TELEPHONE: (703) 923-9536 FAX: (540) 318-6259

RE: AUTHORIZATION FOR MEDICAL RELEASE

_____, DOB: _____

I am writing to authorize the Pain & Arthritis Center, Dr. Cindy Zhang to obtain my medical records on my behalf. Please release my medical records related to treatment rendered by you or under your supervision in relation to the following

_____

SINCERELY,