PLEASE COMPLETE ALL OF THE PAPERWORK IN THIS PACKET. FAILURE TO DO SO WILL RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.

****LOCATED JUST OFF SWEET HOME RD ON RENSCH RD****

PLEASE BRING ALL CONTROLLED SUBSTANCES WITH YOU TO YOUR APPOINTMENT

In Touch Adult Health NP PC
Specializing in Pain Management

Debbra L Hadden MSN, ANP-C
Deborah L Dzielski MSN, ANP-C

New Patient Paperwork

Today's Date _____

Your Name _____ Date of Birth _____

Email _____ Phone _____

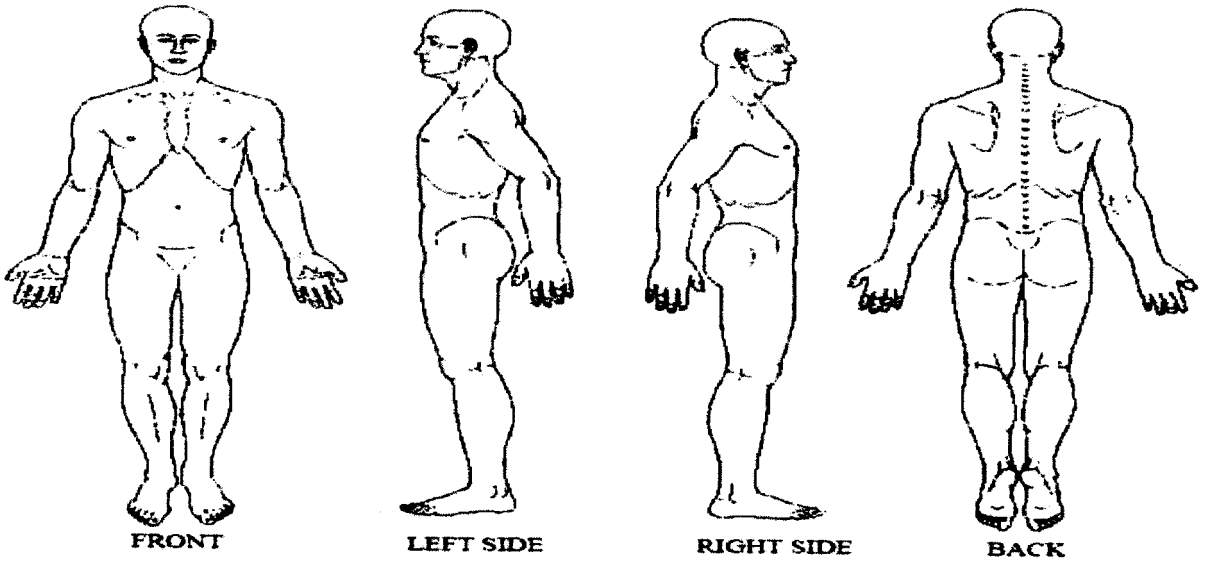
Emergency Contact Name/Relationship _____

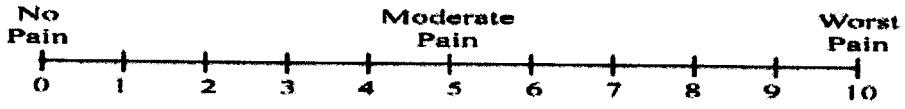
Who is your Primary Care Provider (PCP)? _____

Were you referred to our clinic by another physician? Name _____

Onset of Symptoms and Reason for Visit Today

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: **"N"**umbness **"P"**ins and Needles **"A"**ching **"S"**tabbing **"B"**urning





What is your current pain level **right now**? _____ What is your **worst** level of pain level? _____

Where is your worst area of pain located? _____

Does the pain radiate? If yes, where? _____

Please list additional areas of pain _____

When did this pain begin? _____

What caused your current pain or injury? _____

Was the pain or injury due to a motor vehicle accident or personal injury? ❑ Yes ❑ No

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, has your pain ❑ Increased ❑ Decreased ❑ Stayed the Same

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the Day ❑ Evenings ❑ Middle of Night

Check all that describe your pain **TODAY** -

❑ Aching	❑ Hot/Burning	❑ Shooting	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Cramping	❑ Numb	❑ Spasming	❑ Throbbing	
❑ Dull	❑ Shock-like	❑ Squeezing	❑ Tingling/Pins and Needles	

Diagnostic Tests & Imaging - Mark all of the following tests you have had that are related to your current pain:

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study _____ Date: _____ Facility: _____

❑ Other _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History - Mark all of the following pain treatments you have undergone PRIOR to today's visit:

Treatment	No Relief	Moderate Relief	Excellent Relief
❑ Biofeedback	❑	❑	❑
❑ Bracing	❑	❑	❑
❑ Chiropractic	❑	❑	❑
❑ Decompression Therapy	❑	❑	❑
❑ Epidural Steroid Injection	❑	❑	❑
❑ Home Exercise Program	❑	❑	❑
❑ Medial Branch Blocks or Facet Injections	❑	❑	❑
❑ Medications, please check which ones below -			
❑ Topical Cream	❑	❑	❑
❑ Anti-inflammatories	❑	❑	❑
❑ Muscle Relaxants	❑	❑	❑
❑ Nerve Pain Medications	❑	❑	❑
❑ Physical Therapy, how many sessions _____	❑	❑	❑
❑ Radiofrequency Ablation	❑	❑	❑
❑ Rest	❑	❑	❑
❑ Spine Surgery	❑	❑	❑
❑ Spinal Column Stimulator ❑ Trial ❑ Permanent	❑	❑	❑
❑ TENS Unit	❑	❑	❑
❑ Trigger Point Injections	❑	❑	❑
❑ Other Treatments: _____			

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Other Physicians you have seen to treat your pain

❑ Acupuncturist ❑ Neurosurgeon ❑ Orthopedic Surgeon ❑ Pain Physician ❑ Physical Therapist
❑ Primary Care Provider ❑ Psychiatrist/Psychologist ❑ Rheumatologist ❑ Neurologist
❑ Other _____

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
❑ Bending Backward	❑	❑	❑
❑ Bending Forward	❑	❑	❑
❑ Changes in Weather	❑	❑	❑
❑ Climbing Stairs	❑	❑	❑
❑ Coughing/Sneezing	❑	❑	❑
❑ Driving	❑	❑	❑
❑ Lifting Objects	❑	❑	❑
❑ Looking Forward	❑	❑	❑
❑ Looking Downward	❑	❑	❑
❑ Looking Side to Side	❑	❑	❑
❑ Rising from a Seated Position	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Walking	❑	❑	❑

What other factors worsen or affect your pain that is not listed above? _____

_____

Current Medications

Are taking a **prescribed** **blood-thinner or aspirin**, if so, which one? _____

Name/phone number of the doctor that prescribes your blood thinner _____

Please list **ALL** medications you are currently taking. Attach an additional sheet if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Activity

How many days a week do you exercise? _____ Type of Exercise: ❑ Bicycle ❑ Cardio ❑ Strength

❑ Swimming ❑ Walking ❑ Other _____

Have you had two or more falls in the past year? ❑ Yes ❑ No

Allergies - Please list all allergies that you have:

Medication Name that I'm Allergic to:	The Allergic Reaction I have is:
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Are you allergic to any of the following?

Iodine ❑ Yes ❑ No
Tape ❑ Yes ❑ No
Latex ❑ Yes ❑ No Do you require special rescue measures for your latex allergy? ❑ Yes ❑ No

❑ No Known Allergies

Family History - Mark all appropriate diagnoses as they pertain to your BIOLOGICAL family members only.

Anxiety/Depression	❑	High Blood Pressure	❑
Arthritis	❑	Kidney Problems	❑
Cancer	❑	Liver Problems	❑
Diabetes	❑	Rheumatoid Arthritis	❑
Headaches	❑	Seizures	❑
Heart Disease/Stroke	❑	Substance Abuse	❑

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ❑ I AM ADOPTED (No Medical History Available)

Past Surgical History - Please indicate all surgical procedures you have had done in the past, including the date

Abdominal Surgery:
❑ Gallbladder removal _____
❑ Appendectomy _____

Female Surgeries
❑ Caesarean section _____
❑ Hysterectomy _____
❑ Laparoscopy _____
❑ Ovarian _____

Heart Surgery
❑ Valve replacement _____
❑ Aneurysm repair _____
❑ Stent placement _____

Joint Surgery
❑ Shoulder _____
❑ Hip _____
❑ Knee _____

Spine / Back Surgery
❑ Discectomy (levels) _____
❑ Laminectomy _____
❑ Spinal fusion (levels) _____

Other Common Surgeries
❑ Hemorrhoid surgery _____
❑ Hernia repair _____
❑ Thyroidectomy _____
❑ Tonsillectomy _____
❑ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):
_____
_____
_____

❑ **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE**

Past Medical History /Problem List - Mark all conditions/diseases that you have been DIAGNOSED with:

Cardiovascular / Hematologic
- ❑ Anemia/Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker/Defibrillator
- ❑ Poor Circulation
- ❑ Stroke

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

General Medical
- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Genitourinary/Nephrology
- ❑ Bladder/Kidney Infection(s)
- ❑ Dialysis
- ❑ Kidney Stones
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Urinary Incontinence

Hepatic list active inactive unsure

Hepatitis ❑ A ❑ B ❑ C
❑ active ❑ inactive ❑ unsure

Head/Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Musculoskeletal
- ❑ Amputation/ Phantom Limb Pain
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis/Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Vertebral Compression Fracture

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Tuberculosis
- ❑ Valley Fever

Neuropsychological
- ❑ Alzheimer Disease
- ❑ Anxiety/Depression
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ CRPS/Reflex Sympathetic Dystrophy

Other Diagnosed Conditions:

_____
_____
_____
_____
_____

❑ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

Social History

Alcohol Use: ❑ Current Alcoholism ❑ History of Alcoholism ❑ Never Drinks Alcohol ❑ Social Alcohol Use

Smoker or Tobacco Use: ❑ Current User ❑ Former User ❑ Never

Marijuana Use: ❑ Current User ❑ Former User ❑ Never ❑ Medical Marijuana Card Holder

Drug Use:
- ❑ I Deny Any Illegal Drug Use
- ❑ I am Currently Using Illegal Drugs, list: _____
- ❑ I am Currently Using Someone Else's Prescription Medications, list _____
- ❑ I Formerly Used Illegal Drugs (not currently using); list _____
- ❑ I Have **Abused** Narcotic or Prescription Medications, list _____

Global Pain Scale Please answer all questions

INSTRUCTIONS: **For each question, please indicate your response by circling a number from 0 to 10**

YOUR PAIN:	**0 = No Pain**										**10 = Extreme Pain**
During the *past week,* the **best** my pain has been is	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, the **worst** my pain has been is	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, my **average** pain has been	0	1	2	3	4	5	6	7	8	9	10
During the *past 3 months*, my **average** pain has been	0	1	2	3	4	5	6	7	8	9	10

YOUR FEELINGS: During the past week I have felt:	**0 = Strongly Disagree**										**10 = Strongly Agree**
Afraid.....	0	1	2	3	4	5	6	7	8	9	10
Depressed	0	1	2	3	4	5	6	7	8	9	10
Tired	0	1	2	3	4	5	6	7	8	9	10
Anxious	0	1	2	3	4	5	6	7	8	9	10
Stressed.....	0	1	2	3	4	5	6	7	8	9	10

YOUR CLINICAL OUTCOMES: During the past week:	**0 = Strongly Disagree**										**10 = Strongly Agree**
I had trouble sleeping	0	1	2	3	4	5	6	7	8	9	10
I had trouble feeling comfortable	0	1	2	3	4	5	6	7	8	9	10
I was less independent	0	1	2	3	4	5	6	7	8	9	10
I was unable to work (or perform normal tasks).....	0	1	2	3	4	5	6	7	8	9	10
I needed to take more medication.....	0	1	2	3	4	5	6	7	8	9	10

YOUR ACTIVITIES: During the past week I was NOT able to:	**0 = Strongly Disagree**										**10 = Strongly Agree**
Go to the store	0	1	2	3	4	5	6	7	8	9	10
Do chores in my home.....	0	1	2	3	4	5	6	7	8	9	10
Enjoy my friends and family	0	1	2	3	4	5	6	7	8	9	10
Exercise (including walking).....	0	1	2	3	4	5	6	7	8	9	10
Participate in my favorite hobbies.....	0	1	2	3	4	5	6	7	8	9	10

Review of Systems - Mark all of the following symptoms that you **CURRENTLY** suffer from:

Cardiovascular/Respiratory:
- ❑ Chest Pain
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Swelling in the Feet

Constitutional:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Night Sweats

Ears/Nose/Throat/Neck:
- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hay fever/Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Eyes: ❑ Recent Visual Changes

Gastrointestinal:
- ❑ Constipation
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Nausea/Vomiting

Genitourinary/Nephrology:
- ❑ Blood in Urine
- ❑ Involuntary Urination
- ❑ Loss of Bowel Control
- ❑ Painful Urination
- ❑ Pelvic Pressure

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Neck Pain

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Weakness

Psychiatric:
- ❑ Anxiety/Stress
- ❑ Depressed Mood
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

		OFFICE USE ONLY	
	Mark Each that Applies	**Item Score if Female**	**Item Score if Male**
Family History of Substance Abuse:			
Alcohol	❑	1	3
Illegal Drugs	❑	2	3
Prescription Drugs	❑	4	4
Personal History of Substance Abuse:			
Alcohol	❑	3	3
Illegal Drugs	❑	4	4
Prescription Drugs	❑	5	5
Your Age (Mark box if 16-45)	❑	1	1
Personal History of Preadolescent Sexual Abuse:	❑	3	0
Personal History of Psychological Disease:			
Attention Deficit Disorder, *OR* Obsessive Compulsive Disorder, *OR* Bipolar, *OR* Schizophrenia	❑	2	2
Depression	❑	1	1
❑ **None of the above apply to me**	**TOTAL**		

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true. I authorize In Touch Adult Health and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. In the event that I am asked to provide a urine, oral swab and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine, oral swab and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I give my consent for In Touch Adult Health to retrieve and review my medication history. I understand that this will become part of my medical record.

Signed:_____ Date: _____

Patient or Guardian or Patient Representative

Printed Name: _____

1408 Sweethome Road Suite 12
Amherst, NY 14228
phone 716-458-1100
fax 716-458-1101
www.intouchpainmanagement.com

IN TOUCH ADULT HEALTH NPS, P.C.

Authorization to Release Medical Records to:

In Touch Adult Health NPs, P.C.
Phone (716) 458-1100
Fax (716) 458-1101

I hereby authorize: **In Touch Adult Health NP PC**, located at:1408 Sweet Home Rd. Amherst NY Suite 12

***To REQUEST my Medical Records and/or MRI Imaging Records from*: (List Dr.'s below)**

Patient's Name: _____Phone number: _____
Address: _____
City, State, Zip Code_____
Date of birth: _____ Date of request: _____

Medical Records are to be **sent to: In Touch Adult Health NP PC**, 1408 Sweet Home Rd. Amherst NY Suite 12, 14228.

Fax Number records to be faxed to*: 716-458-1101*

Please check and complete all that apply.
____ Medical Records for Date(s) of: _____
____MRI Imaging and Area for Date(s) of: _____
____Other, please be specific: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address:_____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

I have read this Authorization and I acknowledge being familiar and fully understand its terms and conditions.

_____ _____
Signature of Patient or Personal Representative Date

IN TOUCH ADULT HEALTH NPS P.C.
PAIN MANAGEMENT
FINANCIAL AGREEMENT

You are financially responsible for the medical services you receive at In Touch Adult Health NPs P.C. (hereafter referred to as the "Practice"). Please carefully review this Financial Policy, initial each section and sign the Agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **COPAYMENTS AND DEDUCTIBLES:** Copayments and deductibles for clinic/office visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your copayment.
2. **SELF-PAY:** If you do not have health insurance, or if you health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.
3. **MISSED APPOINTMENTS OR LATE ARRIVALS:** You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. **INITIAL**_____

INSURANCE PAYMENTS

4. **FINANCIAL RESPONSIBILITY:** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment in full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.
5. **COVERAGE CHANGES AND TIMELY SUBMISSION:** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges. **INITIAL**_____

BENEFITS AND AUTHORIZATION:

6. **INSURANCE PLAN PARTICIPATION:** The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your

plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.

7. **REFERRALS:** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. Although, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPPA, you have the right to request restrictions on the disclosure of your PHI. Under HIPPA, the Practice is not required to agree with you. As a matter of course, the Practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.
8. **PRIOR AUTHORIZATION AND NON-COVERED SERVICES:** The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.
9. **OUT-OF-NETWORK PAYMENTS AND DIRECT INSURER PAYMENTS:** You are personally responsible for all charges. If we are not a part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately. **INITIAL**_____

ACCOUNT BALANCE PAYMENTS:

10. **REASSIGNMENT OF BALANCES:** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement. Any unpaid balance will result in a FEE of $5.00 applied to your account for non-payment and further processing fees. INITIAL**_____
11. **COLLECTION OF UNPAID ACCOUNTS:** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in reporting it to the credit bureau and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail address you provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.
12. **PROCESSING FEE FOR CREDIT/DEBIT CARDS:** As of 7/22/2026, the Practice has started collecting a 3% processing fee for using credit/debit cards.

13. **REFUNDS:** Refunds for overpayment are processed only after full insurance reimbursement of all medical services have been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: In TouchAdult Health NPs P.C. ATTN: Billing Department 1408 Sweet Home Road Suite 12 Amherst New York, 14228.
14. **STATEMENTS:** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt. **INITIAL**_____

ADDITIONAL FEES:

15. **MEDICATION RE-FILLS REQUESTS:** All medication refill requests are to be approved by your provider.
16. **MEDICAL RECORD REQUEST:** The Privacy Rule allows you to receive a copy of your personal medical records, billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into the Practice's clinic, the Practice will make every accommodation to fulfill your request. A fee will be charged for medical records requests according to the Public Fee Schedule. There is no charge to transfer a copy of your medical records to a new Provider.
17. **OTHER FORMS:** The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice. Other forms not listed may be considered for completion by the Practice. In these cases, the fee will be determined by the providers. **INITIAL** _____
18. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:** By initialing this section, I acknowledge that I have received and reviewed a copy of the Practice's Notice of Privacy Practice. **INITIAL**_____
19. **PUBLIC FEE SCHEDULE:** By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. **INITIAL**_____

We are pleased to serve you and glad that you chose **In Touch Adult Health NPs P.C. Pain Management** as your provider. We will always strive to provide exceptional care for you.

Reasons that **In Touch Adult Health** may ask you to seek health care services elsewhere might include:

a. Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends.
b. Repeated no shows, cancellations, or continual late arrivals for office visits or procedures.
c. Refusal to adhere to the plan of care as outlined by your Provider or to follow health insurance or government guidelines.
d. Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing. **INITIAL**_____

I have read and understand the Financial Policy of **In Touch Adult Health NPs P.C. Pain Management,** and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice.

This financial policy is binding upon me and my estate, executors and/or administrators, if applicable. **In Touch reserves the right to accept only cash, credit or debit and FSA/HSA cards.** We also accept checks. For any credit card or debit card transaction, there will be a 3% processing fee added.

Printed Name and Date: _____

Patient's Signature: _____

Today's Date: _____

Revised 9/22/26

IN TOUCH ADULT HEALTH NPS PC
Pain Management Opioid Agreement Contract

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your Nurse Practitioner comply with all the state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The Nurse Practitioner's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the Nurse Practitioner/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

PLEASE BE AWARE FROM THIS DAY FORWARD ANY INCONSISTENCIES IN YOUR URINE TOXICOLOGY SCREENS WILL RESULT IN IMMEDIATE TERMINATION FROM THE PRACTICE. INCONSISTENT TOXICOLOGY SCREEN IS DEFINED AS: (1) USE OF ALCOHOL, (2) USE OF ILLEGAL DRUGS, (3) MEDICATIONS NOT PRESCRIBED TO YOU, AND (4) MEDICATIONS THAT ARE PRESCRIBED TO YOU, HOWEVER, ARE COMPLETELY NEGATIVE IN YOUR TOXICOLOGY SCREEN ____ INITIAL

I have agreed to use opioids as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. My Nurse Practitioner is prescribing such medication to help manage my pain. I agree to the following conditions:

1. **I am responsible for my pain medications. I agree to take medication only as prescribed.**
   a. I understand that increasing my dose without the close supervision of my Nurse Practitioner could lead to drug overdose causing severe sedation, respiratory depression, and even death.
   b. I understand that decreasing or stopping my medication without the close supervision of my Nurse Practitioner can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks. ____ INITIAL

2. **I will not request or accept controlled substance medication from any other physician/provider or individual while I am receiving such medication from my Nurse Practitioner at In Touch Adult Health NPs PC. ____INITIAL**

3. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or mobility. Overuse of opioids can cause decreased respiration (breathing).

It is my responsibility to notify Nurse Practitioner of any side effects that continue or are severe (ie., sedation, confusion). I am also responsible for notifying my Nurse Practitioner immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant. ____ **INITIAL**

4. **I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to others because it may endanger that person's health and is against the law.** ____**INITIAL**

5. I should inform my providers of all medications I am taking, including medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl: herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects. ____ **INITIAL**

6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by my Nurse Practitioner. ____**INITIAL**

7. Any evidence of drug hoarding, acquisition of any opioid medication of adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation, loss of prescriptions,or failure to follow the agreement may result in termination of the Nurse Practitioner/patient relationship. ____**INITIAL**

8. I will communicate fully with my Nurse Practitioner, to the best of my ability at the initial and all follow-up visits, my pain level and functional activity along with any side effects of the medications. ____**INITIAL**

9. **I will not use any illicit substances, such as cocaine, marijuana, etc while taking these medications. This will result in complete termination of the Nurse Practitioner/patient relationship and discharge from the practice.** _____ **INITIAL**

10. **The use of alcohol together with opioid medications is contraindicated and will result in immediate discontinuation of controlled substances and discharge from the practice.** _____ **INITIAL**

11. I am responsible for my opioid prescriptions. I understand that:
    a. Refill prescriptions can be written for a maximum of one month supply (30 days) and will be filled at the **same pharmacy.**
       Pharmacy_____ **Phone #** _____
    b. **It is my responsibility to contact the office for prescription refills 7 days prior to the due date.** ____**INITIAL**
    c. **I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen I will report the stolen medication to my Nurse Practitioner, however, if my medications are lost, mis-placed, or stolen my Nurse Practitioner WILL NOT fill medication early, and/or discontinue the medications.** ____**INITIAL**

d. Refills will not be given as an "emergency", such as on a Thursday afternoon because I suddenly realize I will "run out tomorrow". Refills will not be given after office hours or on weekends. ____**INITIAL**

e. Refills can only be filled by a pharmacy in the state of New York. ____ **INITIAL**

f. Prescriptions for pain medicine or any other prescriptions, or change of medication dosage will be done only during an office visit and during regular office hours. No refills of any medication will be done during the evening or on weekends. _____**INITIAL**

g. **You must bring back all opioid medications and adjunctive medications prescribed by your Nurse Practitioner in the original containers/bottles at every visit. Failure to bring medications to your office visit may result in cancellation of your office visit.** _____ **INITIAL**

h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments. _____ **INITIAL**

12. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioid.** ____ **INITIAL**

a. **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to insulin or prednisone. ____ **INITIAL**

b. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/She will be referred to an addiction medicine specialist. ____ **INITIAL**

c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a ***realistic*** decrease of the patient's pain. ____ **INITIAL**

d. If it appears to the Nurse Practitioner that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be tapered.discontinued. I will gradually taper my medication as prescribed by the Nurse Practitioner. ____**INITIAL**

13. If I have a history of alcohol or drug misuse/addiction, I must notify my Nurse Practitioner of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity.** ____**INITIAL**

14. I agree and understand that my Nurse Practitioner reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my Nurse Practitioner may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the Nurse Practitioner/patient relationship. The presence of a non-prescribed drugs(s), illicit drug(s), alcohol, or opiates that are prescribed and are negative

in your urine **WILL BE** grounds for termination of the Nurse Practitioner/patient relationship. Urine drug testing is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. ____ **INITIAL**

I agree to a family conference or a conference with a close friend or significant other ***if the Nurse Practitioner feels it is necessary.*** ____**INITIAL**

15. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from In Touch Adult Health NPs PC. ____ **INITIAL**

I _____ have read the above information or it has been read to me and all my questions regarding the treatment with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

Patient's Signature_____ **Date**_____

9/3/2026

Non-Participation Worker's Comp, Liability, No Fault Acknowledgement Form

1. I acknowledge that I have no open worker's comp cases (work injury)
   Initial___

2. I acknowledge that I have no open No Fault cases (car accident injury)
   Initial___

3. I acknowledge that I have no open liability cases (personal injury cases)
   Initial___

Please list any and all closed and/or settled cases along with the date of injury, the name of the carrier, and the body part covered.

- Name of Insured _____
- Date of Injury _____
- Body Part/s _____

- Name of Insured _____
- Date of Injury _____
- Body Part/s _____

Failure to disclose this information may result in payment in full by patient and *discharged* from the practice!

Signature: _____

Date: _____