Apply sticker from patient sign in sheet here

OFFICE VISIT

UA
- o IPCC
- o CPL
- o Lab Corp
- o Quest

Innovative Pain Care Center
Daniel L. Burkhead, M.D., Ho V. Dzung, M.D., Willis Y. Wu, M.D., Eric J. Brimhall, M.D.
Ryan West, DO, Michael Eastman, PA-C, Michael Scott PA-C, Kelsee McInturf, APRN-CNP

Patient (Print):_____ Date: _____

Date of Birth: _____ Insurance Provider:_____

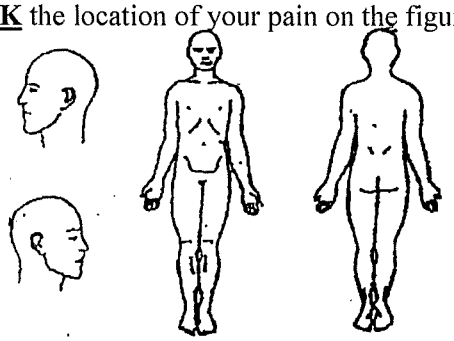
Cell number:_____ Home number:_____email:_____

Pharmacy Name & Phone Number: _____

Place an X at your worst pain and an O at your average since last visit:

0-------1-------2------3------4------5-----6------7-----8-----9------10
None Moderate Severe

MARK the location of your pain on the figure below:



LIST MEDICATIONS PRESCRIBED BY **THIS OFFICE:**

Medication:	Dosage/Mg:	Times Per Day:	Date & Time Last Dose

-What medications are you currently requesting?_____

-Have you seen any other doctors or had any testing since your last visit (MRI, C.T., X-Ray, and/or Nerve Conduction Studies)

YES NO _____

-Any new symptoms (pain, weakness, numbness, bowel or bladder dysfunction, etc.)_____

To Be Completed by Staff

HT: _____ WT: _____ R_____ BP _____ P_____

Procedure Follow-up:

% of Relief:_____% Duration: _____

Current Relief % _____

Pneumococcal Vaccine? Yes No

Care Plan ? No Yes Name & Phone Number:_____Relationship:_____

Treatment Plan:

1. Follow-up visit in _____ weeks w/ Burkhead Dzung Wu West Eastman Scott Kelsee

2. **Procedure:** _____

(Diabetic MRSA SHINGLES ASA NSAID's Coumadin Plavix Other_____) **Tests Performed: ____ MRSA Screen _____ UA/RDS**

3. PT Chiro Radiology Specialist Refer to:_____

_____

Practitioner Signature:_____

INNOVATIVE PAIN CARE CENTER
9920 W. Cheyenne Ave. Suite 110 Las Vegas, NV 89129/
9065 S. Pecos Rd. Suite 230 Henderson, NV 89074/
501 S. Rancho Dr., Suite G-44 Las Vegas, NV 89106
Phone: (702) 316-2281 Fax: (702) 316-2272

Date_____

REGISTRATION FORM **REFERRING PHYSICIAN:**_____

Last Name_____ First Name_____ M.I._____

Street Address_____ City_____ ST_____ Zip_____

Birth Date_____ Age_____ SS#_____ Phone# _____ Cell#_____

Male _____ Female_____ Marital Status: Single ____ Married ____ Separated ____ Divorced _____ Widowed ____

E-Mail: _____ Primary Physician: _____

Employment Information

Employer_____ Address_____

City _____ State _____ Zip Code_____ Phone #: _____

Occupation_____ Other: Not Employed_____ Retired_____ Disabled_____ Student_____

Insurance Information

Primary Insurance_____ Policy Start Date_____

Member/Policy#_____ Group Name/Number_____

Policyholder's Name_____ SS#_____ DOB: _____

Policyholder's Employer_____ Relation to Patient: Self_____ Spouse_____ Child_____ Other_____

Secondary Insurance_____ Policy Start Date_____

Member/Policy#_____ Group Name/Number_____

Policyholder's Name_____ SS#_____ DOB: _____

Policyholder's Employer_____ Relation to Patient: Self_____ Spouse_____ Child_____ Other_____

Accident/Injury Information

Are you currently on WORKER'S COMPENSATION? Yes____ No____ W/C Manager Name / Phone #:_____

Is your condition related to a MOTOR VEHICLE ACCIDENT (MVA)? Yes_____ No_____ Auto Insurance ?: _____

Is your condition related to any OTHER ACCIDENT/INJURY? Yes_____ No _____

Do you have an attorney for any outstanding case regarding your condition? Yes ___ No___ Atty name / phone #:_____

DATE OF INJURY OR ILLNESS (DOI):_____ ***If you have an attorney for LIEN, please provide name, address and phone number for your attorney in the Primary Insurance section above.**

Emergency Contact Information

Emergency Contact:_____ Phone_____ Relation to you_____

Name:_____ Date of Birth: ___/___/_____ Today's Date:___/___/_____

Pain Management Questionnaires

The following are some questions given to all patients at Innovative Pain Care Center who are on or being considered for opioids for their pain. There are 3 sections to complete. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Section 1 of 3: OPIOID RISK TOOL

Please complete one column according to your gender and circle the number in the column if your answer is "yes."

	Female	Male
Do you have family members who abuse the following currently or in the past:		
Alcohol?	1	3
Illegal Drugs?	2	3
Prescription Drugs?	4	4
Do you abuse the following currently or in the past:		
Alcohol?	3	3
Illegal Drugs?	4	4
Prescription Drugs?	5	5
Are you between the age of 16 and 45?	1	1
Did you experience sexual abuse in your pre-adolescent years?	3	0
Do you have the following psychological illnesses:		
ADD, OCD, bipolar or schizophrenia?	2	2
Depression?	1	1

Webster LR, Webster R. Pain Med. 2005; 6 (6): 432

ORT Score:_____

Name:_____ Date of Birth: ___/___/_____ Today's Date:___/___/_____

Section 2 of 3: PATIENT HEALTH QUESTIONNAIRE-9

Please circle a number between 0 and 3 for each question:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or over-eating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or that you want to hurt yourself in some way	0	1	2	3

Robert L Spitzer, Janet BW Williams, Kurt Kroenke and colleagues

PHQ9 Score:_____

Name:_____ Date of Birth: ___/___/_____ Today's Date:___/___/_____

Section 3 of 3: SOAPP-R	Never	Seldom	Sometimes	Often	Very Often
How often do you have mood swings?	0	1	2	3	4
How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
How often have you felt impatient with your doctors?	0	1	2	3	4
How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
How often is there tension in the home?	0	1	2	3	4
How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
How often have you been concerned that people will judge you for taking pain medication?	0	1	2	3	4
How often do you feel bored?	0	1	2	3	4
How often have you taken more pain medication than you were supposed to?	0	1	2	3	4
How often have you worried about being left alone?	0	1	2	3	4
How often have you felt a craving for medication?	0	1	2	3	4
How often have others expressed concern over your use of medication?	0	1	2	3	4
How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
How often have others told you that you had a bad temper?	0	1	2	3	4
How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
How often have you run out of pain medication early?	0	1	2	3	4
How often have others kept you from getting what you deserve?	0	1	2	3	4
How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
How often have you attended an AA or NA meeting?	0	1	2	3	4
How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
How often have you been sexually abused?	0	1	2	3	4
How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

SOAPP Score: _____

Controlled Substance Questionnaire

	Yes	NO	N/A
Have you ever used a controlled substance in a way other than prescribed?			
Have you ever diverted a controlled substance to another person?			
Have you ever taken a controlled substance that did not have the desired effect?			
Are you currently using any drugs, including alcohol or marijuana?			
Are you using any drugs that may negatively interact with a controlled substance?			
Are you using any drugs that were not prescribed by a practitioner that is treating you?			
Have you ever attempted to obtain an early refill of a controlled substance?			
Have you ever made a claim that a controlled substance was lost or stolen?			
Have you ever been questioned about your pharmacy report or PMP report?			
Have you ever had blood or urine tests that indicate inappropriate usage of meds?			
Have you ever been accused of inappropriate behavior or intoxication?			
Have you ever increased the dose or frequency of meds without telling your provider?			
Have you ever had difficulty with stopping the use of a controlled substance?			
Have you ever demanded to be prescribed a controlled substance?			
Have you ever refused to cooperate with any medical testing or examinations?			
Have you ever had a history of substance abuse of any kind?			
Has there been any change in your health that might affect your medications?			
Have you misused or become addicted to a drug, or failed to comply with instructions?			
Are there any other factors that your practitioner should consider before prescribing?			

Patient's Signature _____ Patient's Printed Name _____ Date _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

NECK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0...1...2...3...4...5...6...7...8...9...10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

Section 1– Pain Intensity
___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2– Personal Care (washing, dressing, etc.)
___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

Section 4– Reading
___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration
___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work
___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely do any work at all.
___ I cannot do any work at all.

Section 8- Driving
___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping
___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation
___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

Patient Name (Print) _____ Patient Signature _____ Date _____

FOR OFFICE USE ONLY:

_____ x 2 = _____

Total Points Disability Percentage Rating Scale

WRITTEN INFORMED CONSENT FOR CONTROLLED SUBSTANCE THERAPY FOR PAIN

Nevada law requires a patient's informed consent before a controlled substance can be initially prescribed to treat the patient's pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities that my practitioner has made me aware of. The purpose of this agreement is to help both me and my practitioner comply with the law.
(Please sign below to indicate your understanding of all parts of this document.)

1. **It is my responsibility to maintain compliance with my practitioner's treatment plan. This includes the responsibility of using the controlled substance properly, as prescribed, and taking the medication as directed.**

   ----- I have discussed my treatment plan with my practitioner, **Innovative Pain Care Center: Dr. Daniel Burkhead, Dr. Ho Dzung, Dr. Willis Wu, Dr. Ryan West, Michael Eastman, PA-C, Kelsee McInturf, APRN-CNP, Michael Scott, PA-C** , and I have a good understanding of the overall treatment plan and goals of treatment. I may be given prescriptions for controlled substances; including opioids. My practitioner has discussed specific risks and benefits of these drugs as well as possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that a controlled substance may provide some benefit for the treatment of my pain.

   ----- I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

   ----- When I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

   ----- I understand my practitioner's protocol for addressing any requests for refills.

   ----- If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

2. **It is my responsibility to understand the risks and benefits of using a controlled substance, including the possibility of addiction.**

   ----- There are potential risks and benefits associated with the use of controlled substances for the treatment of pain and I understand these risks and benefits regarding the medication that I've been prescribed.

   ----- I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing.

   ----- Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises.

   ----- I understand that I may become physically dependent these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep disruption.

----- I understand that there is a risk of addiction to controlled substances. If I cannot control my usage of the medication then I may be referred for addiction treatment.

----- I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana) this risk is increased.

----- Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone (Narcan®) is available, without a prescription, and I can obtain this medication from a pharmacist at any time.

----- I have been made aware that there are controlled substances designed to deter abuse available to me and there are risks and benefits associated with those drugs.

3. **It is my responsibility to communicate important information to my practitioner.** If I or anyone in my family has had problems with mental illness or with abuse or misuse of alcohol or other drugs, I will inform my practitioner, as this may put me at greater risk of developing an addiction. I will also inform my practitioner of any change in my health status or any other circumstance which may impact my usage of medication.
4. **It is my responsibility to store and dispose of controlled substances in the appropriate manner.** Prescriptions for controlled substances should always be stored in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a "drug-take back day" station, or I may safely dispose of them by dissolving them in a "Dettera" bag, which may be available for purchase at a pharmacy.
5. **For Women (ages 15-45):** It is my responsibility to tell my practitioner if I am or have reason to believe that I am pregnant or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).
6. **For the Parent or Guardian of un-emancipated minor:** In addition to the above, there are risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person and I have an understanding about ways to detect such abuse, misuse or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I give my consent for the prescription of controlled substances to treat my pain condition.

_____	_____	_____
Patient Signature	Patient name printed	Date
_____	_____	_____
Parent/Guardian	Parent/Guardian name printed	Date

PRESCRIPTION MEDICATION AGREEMENT FOR CONTROLLED SUBSTANCE THERAPY FOR PAIN

Nevada law requires a patient to enter into a "Prescription Medication Agreement" if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities that my practitioner has made me aware of. The purpose of this agreement is to help both me and my practitioner comply with the law.
(Please sign below to indicate your understanding of all parts of this document.)

1. **I understand my overall treatment plan and I understand the goals of the treatment of my pain, including the appropriate use of a controlled substance.**
   ----- I have discussed my treatment plan with my practitioner, **Innovative Pain Care Center: Dr. Daniel Burkhead, Dr. Ho Dzung, Dr. Willis Wu, Dr. Ryan West, Michael Eastman, PA-C, Kelsee McInturf, APRN-CNP, Michael Scott, PA-C** , and I have a good understanding of the overall treatment plan and goals of treatment. My practitioner has discussed possible alternative treatments for my pain that do not include controlled substances and it is our mutual decision that continuation of a controlled substance for more than 30 days may provide some benefit for the treatment of my pain. I may be continued on controlled substance(s); including opioids.
   ----- I understand that part of the goals of my pain management therapy may likely include attempts to minimize or discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend tapering or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means, the presence or development of side effects, any signs of misuse, abuse, diversion, or addiction, refusal to comply with diagnostic studies or other aspects of the treatment plan, attempts to obtain medication from another provider, use of illicit drugs or other medications that may interact with the controlled substance, or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.
   ----- I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner. I will keep the medication safe, secure, and out of the reach of children and I will dispose of unused medication appropriately.
   ----- I understand that controlled substances can cause certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing, and possibly fatal overdose. Due to this risk of fatal overdose, the antidote naloxone (Narcan®) is available, without a prescription, at pharmacies.
   ----- I understand that while taking these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.
   ----- I understand the risks and benefits associated with the use of controlled substances for the treatment of pain for greater than 30 days, including the risk of abuse, misuse, tolerance, dependence, and addiction.
2. **It is my responsibility to maintain compliance with my treatment plan.**
   ----- I will keep, and be on time for, all scheduled appointments with my practitioner.

----- I understand that prescriptions will only be provided during scheduled office visits, and it is my responsibility to make sure that I have scheduled an appointment for refills (typically 30 days in advance). I understand that a minimum of a 5-7day notice may be necessary to get in for an appointment for medication refills. I will not call between appointments, at night, or on weekends to attempt to obtain refills.

----- I understand that my medication is my responsibility and if it is lost or stolen, the medication will not be replaced until my next appointment and may not be replaced at all.

----- I will treat the office staff respectfully at all times and I may be subject to discharge from the clinic if I am disrespectful to staff or disruptive to the care of others.

----- If my treatment for pain goes beyond ninety (90) days, I realize that I will be required by Nevada law to complete an assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

3. **It is my responsibility to communicate important information to my practitioner.**

   ----- I agree to inform my practitioner if I have ever taken a controlled substance in the past, and if it provided the intended effect. I will also inform my practitioner if I am ever given a prescription for a controlled substance by another provider, prior to filling or taking that medication.

   ----- I will inform my practitioner if I use alcohol, marijuana, or any other illicit drugs.

   ----- I will inform my practitioner if I have ever been treated for side effects or complications relating to the use of controlled substances.

   ----- If I or anyone in my family has had problems with mental illness or with abuse or misuse of alcohol or other drugs, I will inform my practitioner, as this may put me at greater risk of developing an addiction. I will also inform my practitioner of any change in my health status, any new medications that have been prescribed, or any other circumstances which may impact my usage of a controlled substance.

4. **I understand that I am strictly prohibited from sharing the controlled substance with anyone or giving or selling the medication to any other person.**

5. **I understand that, as part of my treatment monitoring, periodic body fluid testing (urine, blood, saliva, etc.) may be required at the discretion of my practitioner. I will consent to such monitoring when deemed necessary by my practitioner.**

   ----- I agree to come in to the clinic for such monitoring and testing within 24 hours of being contacted by the office, and if I refuse, or am unable to do so, then my treatment with controlled substances may be discontinued, at the discretion of the practitioner.

   ----- I agree to bring any and all vials of my current medications to the office within 24 hours of being contacted, in order to have my practitioner perform a pill count.

6. **I agree to sign a release form to let my practitioner obtain records from other clinics and speak to other practitioners about my current or prior medical care.**

   ----- It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.

   ----- I will keep up to date with any bills from the office, and I will inform the office of any change in my health insurance or payment method. I agree to pay the copayment or coinsurance fees required by my insurer at the time of service.

   ----- I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Medical, Dental, or Nursing Boards.

7. **I agree to fill all of my prescriptions from only one pharmacy. My pharmacy is:**

---------- ----------

Pharmacy Name **Pharmacy Phone Number**

Pharmacy Address

8. **I understand that Nevada state law requires me to provide a listing of every state in which I have previously resided, or had a prescription for a controlled substance filled. Below is a listing of such states:**

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9. **I understand that if I violate any part of this agreement, then I may be denied prescriptions for controlled substances and I may be discharged from the clinic.**

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree to abide by the rules of this Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment of my pain condition.

Patient Signature	Patient name printed	Date
Parent/Guardian	Parent/Guardian name printed	Date

Innovative Pain Care Center

9920 W. Cheyenne Ave Ste 110
Las Vegas, NV 89129

9065 S. Pecos Rd., Ste 230
Henderson, NV 89074

501 S. Rancho Dr. Ste G-44
Las Vegas, NV 89106

(702) 316-2281 - Fax: (702) 316-2272

Date : {--}

Dear Primary Care Provider / Referring Provider:

This letter is intended to inform you of the ongoing pain management care of our mutual patient, {----}.

This patient has been continuing treatment in our chronic pain management clinic. The treatment plan may consist of a combination of physical modalities, medication management, and interventional procedures, possibly including steroid injections. The rationale for continuation of these treatments involves the patient's preference to avoid surgery. If repeat steroid injections are employed, they will be repeated only if the patient has had a recurrence of pain in the same location that was previously relieved with similar steroid injections for at least 3 months. It is our judgment that the benefits of additional steroid injections outweigh the risks of repeated steroid administration.

Please do not hesitate to contact our clinic with any questions.

Sincerely,

Innovative Pain Care Center

Dr. Daniel Burkhead, MD
Dr. Ho Dzung, MD
Dr. Willis Wu, MD
Dr. Ryan West, DO

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Please Provide our office with your Primary Care Physician Information or Referring Doctor Information if you do not have a primary care physician. New Insurance Guidelines require us to inform your Primary care physician or referring physician of ongoing treatment.

Primary Care Physician/Referring Physician Information:

Name: _____

Phone:_____ Fax:_____

HIPAA Privacy Authorization Release:

I authorize Innovative Pain Care Center to release information to my medical provider listed above.

Name: _____ Signature:_____