Colorado Pain Relief & Wellness Inc.
4990 Kipling St.
Ste. B-5
Wheatridge, Co. 80033
Phone: 303-456-4882 Fax: 303-456-4875

Patient Application Date _____

Personal Information

First Name: _____ MI: _____ Last Name: _____

Gender: ____M ____F SSN: _____-____-_____ Age: _____ D.O.B: _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widow ____ Separated

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Cellphone: (____) _____-_____ Fax: (____) _____-_____

Non-Work Email: _____ Best Time To Call: _____

Working Status: ___ Employed ___ Retired ___ Disability ___ Student ___ Other

Emergency Contact

Emergency Contact Person: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Cellphone: (____) _____-_____

Employer Contact Information

What is/was your occupation: _____

Your Job Title: _____ Employer's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (____) _____-_____ Supervisor's Name: _____

How did you hear about Colorado Pain relief (CPR)? (Please be specific and write the name of the doctor, friend, newspaper, internet, or other):

_____

Acknowledgement, Consent, and Disclosure

1. **This Acknowledgement, Consent, and Disclosure** ("Acknowledgement"), made this _____ day of _____, 20____, by (Print Your Name)_____, an individual with a medical condition desiring treatment ("Patient") at Colorado Pain Relief & Wellness Inc., a medical office in the state of Colorado, by the treating physician at Colorado Pain Relief & Wellness Inc..

1. **Goals of Medical Treatment.** Treatment of Patient's medical conditions and improvement in Patient's quality of life are the goals of the medical treatment at the Colorado Pain Relief & Wellness Inc..

1. **Medical Treatment.** During the course of medical treatment, Physician may prescribe narcotic and other medications ("Medications") for the management of pain, stress, anger, depression, sleep disturbances, opiate reduction therapy, or other medical conditions as diagnosed and treated from time to time ("treatment").

1. **No Guarantees or Assurances Regarding Results from Treatments.** No guarantees or assurances have been made to the Patient regarding specific results that the Patient may expect from obtaining Treatment. The proper use of Treatment for pain is not the total elimination of pain, but rather a significant reduction in pain so Patient will be better able to perform the many activities of Patient's daily life.

1. **Adverse Reactions.** Medications have potential to produce side effects in Patient. Some of them are, but are not limited to: Respiratory Depression, impairment of mental and/or physical abilities, Lightheadedness, Sedation, among others. Patient should refrain from the performances of potentially hazardous tasks and inform the Physician about any of these side effects.

1. **Withdrawal Symptoms.** Abrupt discontinuation of Medications may result in withdrawal symptoms. Withdrawal symptoms usually occur 24-48 hours after taking the last dose of Medications. Patient agrees not to discontinue Treatment or Medications without procuring the consent of the Physician at Colorado Pain Relief & Wellness Inc..

1. **Patient's Responsibilities Toward Medications.** Patient understands violations of the following provisions in the section 7 may be violations of the specific laws and/or regulations of local, state, federal, or other governmental or regulatory bodies ("Laws") and may result in criminal prosecution of Patient. Colorado Pain Relief & Wellness Inc. may have a duty under Laws to disclose the violation to the proper authorities. Patient will be terminated if any of the following occurs:

a. Attempts to acquire Medication from any third party (Doctor Shopping).
b. Does not acknowledge and agree to consume medications strictly as instructed by Physician.
c. Increases the instructed dosage of medications without procuring the consent of the Physician.
d. Consumes excessive amounts of alcohol or uses illegal drugs or other substances.

e. Shares, sells, or trades medications for any reason.
f. Continued loss or report stolen of prescribed medications.
g. Recurrent request of early renewals.
h. Presents fake documentation, alters any medical evidence with the intention to acquire prescribed medications.
i. Unjustified absence of follow up visits.
j. Failure to comply (refuse), leave the premises when requested to take a random urine test and or failure to test positive for prescribed medications or testing positive for illegal substances or non-prescribed drugs.
k. Any other potential aberrant behavior that might cause suspicious conduct.
l. Inability or refusal to adhere to the Rules and Policies of Colorado Pain Relief & Wellness Inc..

1. **Authorization for the Treatment and Random Urine Drug Screen Test.** Patient understands he/she authorizes treatment for the purpose of pain management, anxiety, sleep disturbances, among other medical conditions, following with the recommendation of the attending Physicians. Patient also understands and authorizes random drug tests at any time while he/she is under care of the attending Physician at the Colorado Pain Relief & Wellness Inc..

1. **Patient's Privileges, Rights of Privacy, and Confidentiality.**
    a. Patient agrees to waive any applicable privilege, right of privacy or confidentiality with respect to the investigation of any possible misuse, sale, or other diversion of medications.

    a. Patient acknowledges and agrees the Laws may require Colorado Pain Relief & Wellness Inc. to report incidences of some communicable diseases to governmental agencies such as the Department of Health. Colorado Pain Relief & Wellness Inc. fully respects Patient's fundamental rights to privacy and will only disclose such information as is required under the Law. Patient does agree to waive any rights and privileges Patient may have in this information and permit Colorado Pain Relief & Wellness Inc. to disclose the information as specifically required to comply.

1. **Patient's Comprehension of Acknowledgement and Responsibility to Inquire.** Patient has read, understands, consents to and accepts this Acknowledgement and has the responsibility to inquire. If Patient does not fully comprehend every provision hereof.

By signing below, Patient acknowledges that Patient has read, understands, consents to and accepts this Acknowledgement.

Dated this _____ day of _____, 20____

Patient's Printed Name: _____

Patient's Signature: _____

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Agreement for Long-term Controlled Substances Therapy for Chronic Pain

Consent form derived from the American Academy of Pain Medicine

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, you, the patient, as consideration for, and a condition of, the willingness of the physician who signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain agree to the following policies: **(Please initial)**

1. _____All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. Multiple sources can lead to unwanted drug interactions or poor coordination of treatment.

1. _____ All controlled substances must be obtained at the same pharmacy, where possible.

1. _____ You must inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

1. _____ The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

1. _____ You must not share, sell, or otherwise permit others to have access to these medications.

1. _____ These drugs should not be stopped abruptly, as a withdrawal syndrome will likely develop.

1. _____ U**rine screens will be required at every visit, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment of addictive disorder. You have the right to have screenings tested by an outside facility. However, this will be at your expense.**

1. _____ Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They must not be left where others might see or otherwise have access to them. KEEP THEM LOCKED UP!

1. _____ Since the medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child; you must keep them out of reach of such people. KEEP THEM LOCKED UP!

1. _____ **Medications will not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, eaten by the dog, or for any other excuse. NO EXCEPTIONS.**

1. _____ Early refills will not be given for any reason.

1. _____ Prescriptions may be issued early if the physician or patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that they are not to be filled prior to the appropriate date.

1. _____ If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining the medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

1. _____ It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

1. _____ Renewals (refills) are contingent on keeping scheduled appointments. We do not provide refills by telephone or after hours or on weekends.

1. _____ It is understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

1. _____ The risks and potential benefits of these therapies are explained elsewhere and you acknowledge that you have received such explanation.

1. _____ You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Physician Signature Patient Signature

_____ _____

Date Patient Name (Printed)

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Consent for Chronic Opioid Therapy

Consent derived from the American Academy of Pain Medicine

This physician is prescribing opioid medicine, sometimes called narcotic analgesics, to me for the diagnosis of Chronic Pain Syndrome caused by my specific injury or condition.

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medication has certain risks associated with it, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medication will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed include osteopathic manipulative medicine, rehabilitation, pain management consultation/injections and surgery.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Tawlin), buprenorphine (Buprenex) and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these medicines while I am taking my pain medicines can cause symptoms like a bad flu, called withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am

aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using the medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience withdrawal syndrome. This means I may have any of all the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause my doctor to choose another form of treatment: (Please initial respectively)

_____ (Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

_____ (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medication; I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have birth defect while I am taking an opioid.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I will give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature: _____ Date: _____

Witness to above: _____

Code of Conduct

Please initial each line.

1. _____ Patient will dress accordingly and appropriately at a courtesy for the doctor, staff, and other patients for every office visit.
2. _____ Patient will not leave once inside for their visit. (Ex. NO smoking breaks, NO going outside to talk on the phone, etc.

1. _____ Patient will park only in the designated parking area.

2. _____ If being accompanied, each patient may only bring one person
3. _____ If being dropped off the driver and occupants must leave the premises entirely. They may not wait in the car, they may not wait outside, they must LEAVE. Absolutely NO LOITERING!!

6. _____ Patient must be here on time for their appointments.

CPR Office Policies

4990 Kipling St. Suite B-5 Wheat Ridge, CO. 80033

- ☒ Patient must be at least 25 years of age. (If less than 25, the doctors approval must be confirmed before being admitted)
- ☒ Valid Driver's License or I.D. required. No copies accepted.
- ☒ MRI or CT scan must not be older than 2 years old and will be verified.
- ☒ Patient's most recent Colorado PDMP pharmacy report will be printed and verified.
- ☒ All patients will be drug-tested during the initial visit, and randomly at least twice in a 6 month period.
- ☒ Patients are examined by the Doctor or P.A. at every visit.
- ☒ Patients must participate in therapeutic exercise to help reduce the pain and strengthen the injured area.
- ☒ Patients must have discharge summary from prior clinic if changing pain doctors.
- ☒ If a patient requires Oxycodone, no more than 3 tablets per day will be prescribed. (Maximum quantity of 90 PER MONTH).
- ☒ Patients requiring exceptionally high doses of narcotics will be referred for evaluation for surgery or an appropriate medical specialist.
- ☒ No Psychotic related drugs will be prescribed such as Xanax, Ativan, Klonopin, etc.
- ☒ No Narcotic Break-through pain medications will be prescribed.
- ☒ Grounds for dismissal:
- o Not following doctor's orders
- o Fraudulent MRI report, CT scan, or pharmacy print outs.
- **o Failed drug test** (using **illegal drugs** and/or **not taking pain medication as prescribed).**
- o Pregnancy
- o Continuous loss of prescriptions/ medications being stolen
- o Consciously running out of medications early.
- o Refusal of urinalysis
- o Blatantly being rude/disrespectful to staff

PATIENT SIGNATURE_____**Date** _____