MIDLAND MEDICINE, PA
J. Hunter Atkins, M.D.
1407 West Illinois Avenue
Midland, TX 79701
432-683-8516 Phone
432-683-2324 Fax

Date: ____/____/_____

Name: _____
Last First Middle

Gender: _____ Male _____ Female

Date of Birth: _____ Height: _____ Weight: _____
Social Security_____-___-_____
Patient Contact Information: (Check your preferred method of contact for reminders and updates)

Mobile Number: _____
- ☐ Text Message
- ☐ Phone Message

Home Number:_____
- ☐ Phone Message

May we leave a detailed message at these numbers?
- ☐ Yes
- ☐ No

Email: _____
- ☐ Patient Portal Notification to Email

Current Mailing Address: _____

_____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____
Spouse's Name _____ If Applicable

Emergency Contact:

Name: _____
Relationship to Patient: _____
Contact Phone Number(s): _____
May we share your medical information with this person?
- ☐ Yes
- ☐ No

Referring Provider: _____

Primary Care Provider: _____

Other Physicians: _____

_____

Preferred Pharmacy: _____

Preferred Imaging Center/Location: _____

Payment Information

Form of Payment:

- ☐ Health Insurance
- ☐ Auto Insurance
- ☐ Worker's Compensation
- ☐ Self-Pay
- ☐ Other (Please specify): _____

<u>Primary Insurance</u>

Primary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____

<u>Secondary Insurance</u>

Secondary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____

Referral Source

How did you hear about us?

- ☐ Primary Care Physician
- ☐ Other Physician (Please specify practice specialty): _____
- ☐ Other healthcare provider
- ☐ Insurance Company
- ☐ Attorney
- ☐ Friend/Word of Mouth
- ☐ Internet
- ☐ Social Media

_____Employed _____Unemployed _____Retired _____Disabled

Employer_____Phone_____

Occupation_____

Current Medications:

Please list ANY medications, whether over-the-counter or prescription, that you are currently taking:
(Please add to back of page as needed)

Medication	Dosage	Frequency

Allergies

If you are allergic to ANY medications, please list the medication name and reaction below:
(Please add to back of page as needed)

Medication	Reaction

Surgical History Or Disease History

Please list prior surgeries or procedures in the table below:

Date	Surgery/Procedure	Physician

I acknowledge that to the best of my knowledge and ability, I have provided Midland Medicine, PA with fully accurate and complete information about my medical history.

_____

Signature of Patient/Guardian/Personal Representative Date

_____ _____

Name of Patient/Guardian/Personal Representative Guardian/Personal Representative's Relationship to Patient

Please List You Pertinent Medical History

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Financial Policy

Because of our commitment to provide you with the highest standard of medical care, we want you to be aware of our policies concerning payment of your medical expenses.

PATIENT PAYMENT RESPONSIBILITY

At all office visits, you will be responsible for any co-payment/co-insurance amounts assigned by the insurance carrier plus any applicable deductible amounts. If there is a balance on your account, you may be asked to pay towards that amount on your visit. Should an overpayment occur on any amount you owe to Midland Medicine, PA, we will apply a credit to your account. A refund is available upon request.

If our office cannot verify your insurance benefits in advance, your insurance carrier sends payment directly to you, you are waiting for coverage to become effective, or if you have no medical insurance coverage, payment in full will be due when you check in for your appointment.

ACCEPTED FORMS OF PAYMENT

Accepted forms of payment are credit card, debit card, check, or cash.

LEGAL GUARDIAN MUST BE PRESENT

We require that a guardian or duly authorized representative accompany a patient who lacks the capacity to make medical treatment decisions, unless the guardian or representative has given prior written authorization to our office to undertake the testing, treatment, or procedure contemplated for the pertinent visit, and Midland Medicine, PA deems it appropriate under the patient's particular circumstances. The guardian or duly authorized representative accompanying the patient is required to pay in accordance with our policies.

_____

Patient/Guardian/Personal Representative Signature Date

Appointment Policies

Midland Medicine, PA strives to provide quality medical care in a timely manner to all of our patients. In order to do so, we ask that you be aware of Midland Medicine, PA's policies as they pertain to appointments. These policies enable us to better utilize available appointment times for our patients in need of medical care. Midland Medicine, PA will accommodate, as fully as possible, patients requesting appointment cancellations subject to the following policies:

CANCELLATION POLICY

In consideration of your fellow patients, **please contact our office at (432) 683-8516** as soon as possible if you need to cancel or reschedule your appointment. We require that you call **at least 24 hours in advance**, and calling early in the day is appreciated. Appointments are in high demand, so your early cancellation will give another patient the opportunity to access timely medical care. If you do not reach the receptionist, you may leave a detailed message with the answering service. Please be sure to leave us your phone number and let us know the best time to return your call.

There will be a $50.00 fee for either failing to show up for a scheduled appointment or canceling a scheduled office visit less than 24 hours in advance. Please be sure to cancel more than 24 hours in advance to avoid these fees.

As a courtesy to our other patients, if you are more than fifteen (15) minutes late for a scheduled office visit or procedure, you may be asked to re-schedule, in which event we will assess the applicable cancellation fee against your account. To avoid these fees, be sure to show up on time or cancel more than 24 hours in advance.

NO-SHOW POLICY

It is the policy of Midland Medicine, PA to monitor and manage appointment no-shows. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. We reserve the right to dismiss from the practice a patient who is a no-show on more than three occasions.

I have read and understand the Cancellation and No-Show Policies of Midland Medicine, PA and agree to comply with them to the best of my ability.

_____

Patient/Guardian/Personal Representative Signature Date

Assignment of Insurance Benefits

I hereby authorize Midland Medicine, PA to file claims with my insurance company and to receive payment for my medical care and/or procedures. Midland Medicine, PA has my permission to release any information required to secure payment of benefits. I authorize the use of my signature below in connection with all insurance submissions. I further authorize payment directly to Midland Medicine, PA of all insurance benefits related to my care. I understand that I am responsible for any co-payments, co-insurance, or deductibles due at the time of any and all office visits or procedures. I also understand that I am financially responsible for all charges not covered by my insurance benefits for services rendered on my behalf. I further understand that bills from Midland Medicine, PA, Explanations of Benefits ("EOBs") pertaining to reimbursement for my care, and other correspondence from this medical practice concerning my account may be sent under the name of, or make reference to, Midland Medicine, PA and/or its Member Physicians, including without limitation J. Hunter Atkins, M.D. I will take action on these items accordingly.

_____

Patient/Guardian/Personal Representative Signature Date

Medicare Authorization

I request that payment of Medicare benefits be made to Midland Medicine, PA on my behalf for any services furnished by Midland Medicine, PA or under its direction. I understand that my signature below requests the assignment of payment for my medical care and authorizes the release of medical information necessary to pay any related claims. I acknowledge that in Medicare assigned cases, Midland Medicine, PA agrees to recognize the allowable charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the difference between the allowable charge and the amount paid by the Medicare carrier pursuant to Medicare regulations. I further acknowledge that although I am a Medicare beneficiary, Midland Medicine, PA may recommend certain procedures or treatments that are either not covered by Medicare or are not covered for use in the manner Midland Medicine, PA has recommended. In such an event, Midland Medicine, PA will undertake its best efforts to consult with me concerning the medical necessity and the unlikelihood of reimbursement for the procedure or treatment in question. I may be asked to sign certain documentation that the Medicare Program requires in such circumstances. I recognize that if I elect to proceed with the procedure or treatment in such an event, I will be personally and fully responsible for payment.

_____

Patient/Guardian/Personal Representative Signature Date

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Disclosure of Health Information

Midland Medicine, PA will not disclose any of your health information to family (including your spouse), friends, or third parties that fall outside of the Notice of Privacy Practices guidelines, unless you authorize us to do so in writing. If there are any persons and/or facilities that you do not authorize to have access to your personal health information, please ask us for and complete a request for restriction form.

CONTACT AUTHORIZATION

Notwithstanding Midland Medicine, PA's right under Texas and federal laws under our Notice of Privacy Practices to provide your medical information to certain persons who in our reasonable judgment are involved in your medical care or payment therefor, we would like for you to give us guidance concerning third parties with whom we might share your medical information and the means of doing so. Accordingly, we inquire, if Midland Medicine, PA needs to contact you about your medical care but is unable to reach you directly, would you like for us to attempt any of the following commonly requested alternatives?

Before you check one or more of the options below, please take into consideration that these messages could include information about your medication(s), test results, insurance coverage, appointment details, benefit payments, account status, or other personal information regarding your care at Midland Medicine, PA.

If unable to contact me directly, I authorize Midland Medicine, PA to (please check the applicable boxes):

- ☐ Leave a voice mail message at this phone number _____
- ☐ Speak to my spouse or significant other whose name is _____
- ☐ Speak to or leave a message with the family members/friends listed below:

Name: _____ Relationship to Patient: _____

Contact Number: _____

Name: _____ Relationship to Patient: _____

Contact Number: _____

I understand that if I want to withdraw authorization for Midland Medicine, PA to share information regarding my care with any of the individuals, or by any of the means, listed above, or if I wish to designate different individuals or means of leaving a message, it is my responsibility to notify Midland Medicine, PA in writing.

_____

Signature of Patient/Guardian/Personal Representative Date

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Notice of Privacy Practices

Effective August 1, 2021

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

THE PURPOSE OF THIS NOTICE

Midland Medicine, PA's Notice of Privacy Practices: This is Midland Medicine, PA's Notice of Privacy Practices ("Notice"). It is applicable to all of our patients. Midland Medicine, PA is referred to in this Notice as "us," "we," or "our." This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as later modified and updated, and by other Texas and federal laws. In general, HIPAA and related statutes deal with your "Protected Health Information," which HIPAA defines as personal information that identifies you and relates to the diagnosis and treatment of your past, present, or future physical or mental health condition(s). For the sake of simplicity, this Notice uses the term "medical information" instead of "Protected Health Information."

Further Information: We strive at all times to deliver high quality clinical services, and we are dedicated to maintaining the privacy of your medical information. We will provide you with a copy of our current Notice when you come to our office for your first appointment. We will ask you, your parent or guardian, or your personal representative, as applicable, to acknowledge in writing your receipt and review of this document. Our current Notice will also be posted prominently in our office and on our website at **1407 West Illinois Ave, Midland, Texas**. If you desire an additional copy of this Notice or you have any further questions or concerns about your medical information, our Privacy Officer, **Our staff**, is available to assist you. You may contact **Midland Medicine** by calling (432)683-8516, by writing to Midland Medicine, PA c/o Privacy Officer, 1407 West Illinois Avenue, Midland, TX 79701, or by emailing us at **Sondra@Midlandmedicine.com**.

OUR DUTIES

We are required by law: to maintain the privacy of your medical information (subject to the contents of this Notice); to provide you with notice of our legal duties and privacy practices with respect to your medical information; and to notify you following a breach of the privacy of your medical information (in the manner prescribed by applicable law). We are required to abide by the terms of our current Notice.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

We may use and disclose your medical information in a number of circumstances and for a variety of reasons, some of which require your prior authorization. There are many situations, however, in which we are legally permitted or required to use and disclose your medical information without your prior authorization. Many of these instances will occur in connection with: a) your treatment, b) payment for healthcare services that we provide to you, and/or c) our routine healthcare business operations. This Notice describes these situations. In some cases we may completely remove any personal identifiers. Specifically, we may use and disclose your medical information as follows:

Permitted Disclosures of Your Medical Information

We may use and disclose your medical information without your prior authorization in the ordinary course of our routine business operations. Such instances include the following:

***Treatment*:** We may use your medical information to facilitate the provision of our services to you. This includes disclosing your medical information to individuals who may need that information to treat you, such as our physicians, physician assistants, nurses, technicians, and other clinical personnel, and others involved in your care, such as primary care physicians or specialists. We may also use and disclose your medical information to remind you of upcoming appointments, inform you about treatment options or alternatives, tell you about healthcare-related services, or monitor and evaluate your experience with us through follow-up communications.

Payment: We may use your medical information to bill and receive payment from your insurance company, you, or any other person/entity responsible for payment on your account. We may also use your medical information when contacting your health plan to see if it will pay for your treatment with us or for any other customary purpose related to billing and payment. You may also request to pay out-of-pocket for the services we provide to you and, in such a case, you may request that we not bill your insurer for such services.

Healthcare Operations: We may also use or disclose your medical information to conduct our normal business and professional operations. For example, we routinely review past examinations, diagnoses, and treatments to assess our service and clinical performance. We might also use your medical information for internal and external review purposes. In addition, we may use your medical information to demonstrate our competencies to an accreditation body. Accreditation is important to you and to us because the process assists us in maintaining our proficiency in performing our medical services. Other operational matters that might require us to use or disclose your medical information include professional and staff training, payor credentialing, risk management activities, insurance underwriting, cost and utilization management, legal and regulatory compliance, facility licensing and certification, and financial accounting and auditing.

Emergency Treatment: We may disclose your medical information if you require emergency treatment or are unable to communicate with us.

***Serious Threats to Health or Safety*:** We may disclose your medical information if, in our professional judgment, doing so would help to avert a serious threat to the public's or your health or safety.

Public Health Activities: We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls of products that they may be using; and/or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose your medical information to proper authorities in accordance with applicable law if we reasonably believe it is relevant to instances of abuse, neglect, or domestic violence.

Family and Friends: We may disclose your medical information to a family member, a friend, or any other person you identify as being involved with your care or payment for your care, unless you object.

Worker's Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Military and Veterans: If you are a member of the armed forces, we may release information about you as required by military command authorities.

Health Oversight Activities**:** If you are the beneficiary of a government healthcare program, we may be required to disclose your medical information to that program or a related agency if it selects your case for medical review.

Disclosures Required by Law: Federal, state, or local law may require us to disclose our patients' medical information for certain legally-mandated purposes.

Specialized Government Functions**:** We may use and disclose medical information of certain individuals for specific national security, military, intelligence, or protective service purposes.

Law Enforcement**:** We may disclose your medical information when legally required by appropriate authorities in connection with a criminal or other official investigation.

Judicial and Administrative Proceedings**:** If information in your medical record is relevant to a legal proceeding, we may be required to comply with a court or administrative tribunal subpoena commanding us to disclose your medical information.

Organ and Tissue Donation: If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.

Coroners, Medical Examiners, and Funeral Directors: We may release information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

Sale of Practice: We may use and disclose medical information about you to another health care facility or group of physicians in connection with the sale, transfer, merger, or consolidation of our practice.

Research: We may disclose your medical information for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your medical information.

Disclosures Requiring Your Authorization

Situations Requiring Written Authorization**:** All uses and disclosures of your medical information not generally described above in this Notice will require your prior written authorization. In those situations, we will ask for the authorization before we release your medical information. Examples of these situations include our: a) compliance with requests to provide medical information to your attorney or to life or disability insurance companies; b) use and disclosure of psychotherapy notes, if any; c) use of your testimonial or photographic images; d) use or disclosure of your medical information for other marketing purposes, including communications intended to inform you of subsidized treatment options offered by specific providers; and e) use or disclosure of your medical information in any way that constitutes its sale.

Revocation of Authorization and Its Effects**:** You may revoke any standing authorization to disclose your medical information by so notifying our Privacy Officer in writing at the physical or email address provided on the first page of this Notice. Your revocation can only be prospective, and we will not request the return of information previously disclosed in reliance on your authorization.

YOUR RIGHTS

You have certain rights with respect to our communication of, your access to, the amendment of, and accounting for the disclosure of your medical information:

***Requesting Restrictions*:** You may ask us to limit our use or disclosure of your medical information under certain circumstances. For example, we may disclose your medical information to an immediate family member(s), other relative(s), or close personal friend(s) who are directly involved either in your care or in the payment for your care if we reasonably determine, based upon our professional judgment, that you would not object. You may, however, request a restriction on what medical information we may disclose to someone who is directly involved either in your care or in the payment for your care. You are entitled to request other restrictions as well. We are not required to agree to your request, but if we agree to it, we will abide by your request, except as required by law, in emergencies, or when the information is necessary to treat you. All such requests must be in writing and directed to our Privacy Officer at the physical or email address provided on the first page of this Notice. Your request must describe the information that you want restricted, state if the restriction is to limit its use or its disclosure, and state the party(ies) to whom the restriction applies. You may revoke your restriction at any time by contacting our Privacy Officer at the physical or email address on the first page of this Notice.

***Confidential Communications*:** In order to protect your medical information, you may ask that we communicate with you in a particular way or at a certain location. Your request must be in writing, tell us how you intend to satisfy your payment obligation (if your request potentially interferes with our obtaining third party payment), and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request. You may revoke your request at any time by contacting our Privacy Officer at the physical or email address on the first page of this Notice. We will accommodate your reasonable request, but in determining whether your request is reasonable, we will consider the administrative burden it may impose upon us.

***Inspect and Copy*:** You may ask to review and obtain a copy of your medical information. You must make your request in writing to our Privacy Officer at the physical or email address on the first page of this Notice. We may charge a fee for copying or preparing a summary of requested medical information. We will respond within 15 days of receiving your request unless your medical information is not readily-accessible or the information is maintained in an off-site storage location. Additionally, you have the right to access your own e-health record in an electronic format and to direct us to send the e-health record directly to a third party. In connection with transfers of e-health records, we may charge for labor costs only, which may include a notary fee and mailing costs if a notarized and/or paper copy is also requested.

***Amendment*:** You may request, in writing, that we make a change or addition to your medical information. To make such a request you may contact our Privacy Officer using the contact information on the first page of this Notice. The law limits your right to change or add to your medical information. Specifically, we may decline to change your medical information: if we did not create the medical information; if it is not included in the medical records we maintain for you; if we believe that the medical information is accurate and complete without any changes; or if the medical information contains information you are not permitted to inspect or copy (such as psychotherapy notes). Under no circumstances will we erase or otherwise delete original documentation in your medical information.

***Accounting of Disclosures*:** You may request a list of non-routine disclosures that we have made of your medical information during the six years prior to the date of your request. This list will not include disclosures we make to provide our medical services to you, to seek payment for our medical services, to conduct our normal business operations, or disclosures we make pursuant to your written authorization. Your first request in a 12-month period is free, but we may charge for additional lists in the same 12-month period. If your medical information is maintained in an electronic health record after December 31, 2013, we must also provide an accounting of

disclosures through an e-health record to carry out treatment, payment, and healthcare operations within the three-year period prior to the date of your request. If you make such a request, we must either: provide you with an accounting of all such disclosures made by us and by all of our Business Associates; or provide you with an accounting of all such disclosures made by us and a list of our Business Associates, including their contact information, who will be responsible for providing an accounting of such disclosures upon your request.

***Breach Notification*:** We are required to notify you if the privacy of your medical information has been breached (as defined in applicable federal regulations). Notification must occur by first class mail within sixty (60) days of the event. The notice of breach must contain: a) a brief description of what happened, including the date of the breach and the date of discovery; b) the steps you should take to protect yourself from potential harm resulting from the breach; and c) a brief description of what we are doing to investigate the breach, mitigate losses, and protect against further breaches.

***Business Associates*:** Like most medical practices we conduct some of our business operations with the help of third-party vendors and contractors known under HIPAA as "Business Associates." In accordance with federal law, we have entered into Business Associate Agreements which provide that all of the HIPAA administrative security safeguards, physical safeguards, technical safeguards, and security policies, procedures and documentation requirements that apply to us also apply directly to each of our Business Associates.

***Paper Copy of Notice*:** You are entitled to receive a paper copy of our Notice of Privacy Practices by contacting our Privacy Officer using the contact information on the first page of this Notice. You may also take a copy of this Notice with you. Even if you have requested this Notice electronically, you may always request a paper copy.

Changes in Our Privacy Practices: We reserve the right to change our medical records privacy practices, as permitted by applicable law. Any changes we make will apply to all medical information we then-currently maintain as well as medical information developed in the future. If we make such a change, this Notice will be amended accordingly, posted prominently in our office and on our website at **Midlandmedicine.com**, and made available to you, upon your request, whenever you subsequently visit our office for care.

File a Complaint*:** If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer using the contact information on the first page of this Notice or with the Office for Civil Rights, U.S. Department of Health and Human Services. Your complaint must be filed in writing within 180 days of when you knew or should have known that the act occurred. You may file a complaint via the Office for Civil Rights secure, on-line portal at https://ocrportal.hhs.gov, which is the recommended method. You may also file a complaint in writing via regular mail, email, or fax. The complaint and consent forms may be found on line at www.hhs.gov/hipaa/filing-a-complaint/complaint-process. The address for filing the completed forms via mail is: U.S. Department of Health and Human Services, Office for Civil Rights, Centralized Case Management Operations, 200 Independence Ave., SW, Suite 515F, HHH Building, Washington, D.C. 20201. The completed forms may also be filed via email to OCRComplaint@hhs.gov or via fax to 202-619-3818. Finally, you may call the Office for Civil Rights Customer Response Center at 1-800-368-1019. ***You will not be penalized or retaliated against for filing a complaint.

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Acknowledgement of Access to Notice of Privacy Practices

I acknowledge that Midland Medicine, PA's Notice of Privacy Practices is available to me at any time by reviewing it on their website at **MidlandMedicine.com**, by requesting a copy at any of their office locations, by requesting that it be sent to me electronically, or by contacting Midland Medicine, PA's Privacy Officer using the contact information set forth on the first page of the Notice of Privacy Practices. I also acknowledge that before signing this Acknowledgement, Midland Medicine, PA afforded me the opportunity to read and ask questions about the Notice of Privacy Practices.

_____

Signature of Patient/Guardian/Personal Representative Date

_____ _____

Name of Patient/Guardian/Personal Representative Guardian/Personal Representative's Relationship to Patient

MIDLAND MEDICINE, PA
J. Hunter Atkins, M.D.
1407 West Illinois Avenue
Midland, TX 79701
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Authorization to Disclose to Medical Information

TO: _____
Name of Healthcare Provider

_____
Street Address Phone Number

_____
City State Zip Code

RE: Patient Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

Patient authorizes and requests that Healthcare Provider disclose Patient's medical information as described below for the purpose of review, evaluation, and presentation in connection with Patient's further medical evaluation, diagnosis, and treatment. Patient requests that Healthcare Provider's Custodian of Records disclose Patient's medical information to include the following:

- Any and all hospital and medical records or reports of any sort, charts, notes, x-rays, other radiographic studies, lab reports, and prescription information, including the right to inspect and copy such records; and
- Any and all other information pertaining to any confinement, examination, treatment or condition of Patient, including medical, dental, psychological or other treatment, examinations, or counseling for any medical condition.

Healthcare Provider may disclose Patient's medical information ***for all times*** when Patient received Healthcare Provider's medical attention.

Disclosure to be made to: Midland Medicine, PA
1407 West Illinois Avenue
Midland, TX 79701
Attn: **SONDRA**

Patient understands that this authorization allows disclosure and use of medical information of Patient, which is protected under federal and state law. Patient also understands that any disclosure of medical information carries the potential for re-disclosure where the information might no longer be protected by law.

Patient understands that Patient has a right to revoke this authorization at any time. Revocation must be in writing and should be directed to Healthcare Provider's Custodian or Records/Privacy Officer at Healthcare Provider's address listed above. Patient further understands, however, that Patient's revocation will not be valid as to any actions Healthcare Provider may take in reliance on this authorization before it receives Patient's revocation and that Healthcare Provider will have no obligation to retrieve information it disclosed while this authorization was still in effect. **This authorization will expire two (2) years after the date it is signed.**

_____
Signature of Patient/Guardian/Personal Representative Date

_____ _____
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Opioid Treatment Agreement

Opioid treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to perform daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist with your return to work ("RTW") efforts.

I, _____, understand that my compliance with the following commitments is a condition of continuing opioid treatment for chronic pain with Midland Medicine, PA.

1. I understand that I have the following responsibilities:
    a. I will take medications only at the dose and frequency prescribed.
    b. I will not increase or change medications without the approval of my treating physician.
    c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
    d. I will not request opioids or any other pain medicine from physicians other than my treating physician at Midland Medicine, PA. My treating physician should approve or prescribe all other mind and mood-altering drugs.
    e. I will inform my treating physician of all other medications that I am taking.
    f. I will obtain all medications from one pharmacy, when possible known to Midland Medicine, PA and my treating physician. By signing this Agreement, I give full consent for my treating physician or an authorized representative of Midland Medicine, PA to talk with the pharmacist about all of my medications.
    g. I will protect my prescriptions and medications, and I will keep all medications from children and other household members.
    h. I agree to participate in psychiatric or psychological assessments, as my physician deems necessary.
    i. I understand that if my medications are lost or stolen, they will not be replaced until my next appointment, and they may not be replaced at all.
    j. I will not call between appointments, or at night or on weekends, looking for refills. I understand that prescriptions will be authorized only during scheduled office visits with my treating physician.
    k. I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, opioid or other medication treatment for chronic pain will be terminated.
    l. I will inform Midland Medicine, PA immediately of any change in my mental or physical health status, including any new diagnosis, medical procedure, or course of treatment.

2. I understand that in the event of an emergency, my treating physician, if available, or Midland Medicine, PA should be contacted so my treating physician or an authorized representative of Midland Medicine, PA can discuss my chronic pain treatment with the emergency room or other treating physician. I am responsible for signing a consent to transfer the record of my emergency treatment to Midland Medicine, PA. No more than 3 days of medications may be prescribed by the emergency room or other physician without my treating physician's approval.

3. To the best of my abilities, I will keep and be on time for my scheduled appointments.

4. I understand that my treating physician may stop prescribing opioids or change the treatment plan if:
    a. I do not show any improvement in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlined in #1, above.
    c. I give, sell, or misuse the opioid medications.
    d. I develop rapid tolerance or loss of improvement from the treatment.
    e. I obtain opioids from a source other than my treating physician without his or her authorization.

f. I refuse to cooperate when asked to get a drug screen.
g. I am identified as having an addiction problem arising from my prescribed treatment or my use of any other addictive substance.
h. I fail to keep follow-up appointments for any reason whatsoever, including any such failure which occurs due to my refusal pay any co-pay, deductible, or charge owed to Midland Medicine, PA.

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:
You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness, tolerance, and impairment of your ability to operate heavy equipment or drive a motor vehicle.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Nausea
- Sleepiness or drowsiness
- Vomiting
- Constipation
- Aggravation of depression
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL OR MUSCLE RELAXERS.

RISKS:
1. **Physical dependence.** This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

- Runny nose
- Difficulty sleeping for several days
- Diarrhea
- Abdominal cramping
- Sweating
- 'Goose bumps'
- Rapid heart rate
- Nervousness

2. **Psychological dependence.** This means it is possible that stopping the drug will cause you to miss or crave it.
3. **Tolerance.** This means you may need more and more drug to get the same effect.
4. **Addiction.** A small percentage of patients may develop addiction problems based on genetic or other factors.
5. **Problems with pregnancy.** If you are pregnant or contemplating pregnancy, discuss this with your treating physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the doses, the time of day you are taking them, their effectiveness, and any side-effects you may be having.
- Use a medication sorting box that you can purchase at your pharmacy that is divided by the days of the week and times of the day so it is easier to remember when to take your medications.
- Use a medication lock box that you can purchase at your pharmacy to lock your medications out of the reach of others and prevent anyone but you from obtaining access to it.
- Take only the amount you need with you when leaving home to reduce the risk of losing all your medications at the same time.

I have read, understand, and hereby make the commitments set forth in this Opioid Treatment Agreement. I will comply with these commitments to the best of my ability, and I hereby consent to opioid treatment for chronic pain in accordance with their terms and conditions.

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Patient Signature Printed Name Date