ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

Dr. Fedoriw

PATIENT HISTORY QUESTIONAIRE ***PLEASE PRINT***

Patient Name: ______________________________ Date: ______________
Date of Birth: __________Age: ____ Weight: _____Height____ __Occupation:______________
Marital Status: (circle) Single Married Divorced Widowed Dominant hand: (circle) Right or Left
Date of Injury or when did you first notice the problem: ______________________
Type of Injury/Illness: ______________________
Were you injured on the job? YES NO
What is your current job description/duties: ______________________

____

____

History of present Illness/injury (how did it happen?):______________________
Have you had any previous treatment or tests for this problem? YES NO
If yes, please list what test or treatment have been performed: ______________________

____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

High Blood Pressure	Yes	No	Cancer Type_________		No
Elevated Cholesterol	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Emphysema/COPD	Yes	No
Asthma	Yes	No	Liver or Kidney Disease	Yes	No
Peptic Ulcers	Yes	No	Bleeding Disorder	Yes	No
Heart Disease	Yes	No	Arthritis	Yes	No
Thyroid	Yes	No	Hepatitis	Yes	No
Osteoporosis	Yes	No			

DO YOU HAVE A FAMILY HISTORY OF:

High Blood Pressure	Yes	No	Cancer Type_________		No
Elevated Cholesterol	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Emphysema/COPD	Yes	No
Asthma	Yes	No	Liver or Kidney Disease	Yes	No
Peptic Ulcers	Yes	No	Bleeding Disorder	Yes	No
Heart Disease	Yes	No	Arthritis	Yes	No
Thyroid	Yes	No	Hepatitis	Yes	No
Osteoporosis	Yes	No			

PLEASE LIST PREVIOUS SURGERIES:

______________________ ______________________

______________________ ______________________

______________________ ______________________

PLEASE LIST MEDICATIONS YOU PRESENTLY ARE ON (*Including dosage and strength*):

______________________ ______________________

______________________ ______________________

______________________ ______________________

Are you Allergic to any Medications? Yes No
If yes, please list all allergies and type of reaction:______________________
Do you Smoke? Yes No If yes, how often? ______________
Do you drink alcohol? Yes No If yes, how often? ______________
Do you take illicit drugs? Yes No

Patient Signature: ______________________________

ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME: ____ **TODAY'S DATE:** ________________

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM. WE MUST HAVE *"BOX 1: CONDITION OR DATE OF INJURY"* COMPLETE TO FILE YOUR CLAIM.

1. Please check: ☐ CONDITION ☐ INJURY INJURY DATE:____/_____/_____ (ON OR ABOUT)

THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary) ______________________________

____

2. Did the injury occur during work? ☐ YES ☐ NO
3. Were you clocked in? ☐ YES ☐ NO
4. Were you at lunch? ☐ YES ☐ NO

THIRD PARTY LIABILITY

5. Is there a possible third party liability? ☐ YES ☐ NO

(INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance may deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a **"non-covered" service** and may make me personally liable for the charges incurred.

SIGNATURE: ____ **TODAY'S DATE:** _____/_____/_____

(RESPONSIBLE PARTY)

ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

ORTHOPAEDIC ASSOCIATES, LLP * FINANCIAL POLICY

WELCOME, and thank you for choosing Orthopaedic Associates, L.L.P. for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Orthpaedic Associates, L.L.P. at the time of service. O.A will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductible or fees for non-covered services are required at the time of service.

HMO/PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with an O.A physician, it is your responsibility to make sure that the physician is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary "charges.

IF YOU DON'T HAVE MEDICAL INSURANCE: we request payment at the time of service of satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call our billing office at 1-888-330-1737 between the hours of 8:30 am and 5:00 pm, Monday through Friday.

MEDICARE: If, you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% Co-Insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic Associates, L.L.P will file Medicare and any supplemental insurance claims to your insurance carrier(s).

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature ______________________________ Date__________________

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ORTHOPAEDIC ASSOCIATES, L.L.P. to release any information acquired in the course of my treatment that may be necessary to process my claim. (I permit a copy of this authorization to be used in place of the original.) In consideration of services rendered, I authorize payment to be made directly to ORTHOPAEDIC ASSOCIATES, L.L.P

Patient Signature ______________________________ Date__________________

ANESTHESIA AND HOSPITAL BILLS

You may also receive separate bills from one or other physician's offices. These bills may cover such expenses as physician services and/or professional interpretation of tests and X-ray. Questions concerning such bills should be directed to the office of the physician who sent the bill.

Patient Signature ______________________________ Date__________________

USE OF A PHYSICIAN ASSISTANT OR CO-SURGEON

As deemed necessary by your physician, a physician assistant or co-surgeon may be necessary to provide the highest level of care during a surgical procedure. For such circumstances, you may be required to provide a surgery deposit for this individual in addition to your physician.

Patient Signature ______________________________ Date__________________

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO Plan.

Patient Signature ______________________________ Date__________________

Dear Patient,

You are receiving this letter as notification of our perspective practices and compliance monitoring program regarding Schedule II medications.

The Drug Enforcement Administration (DEA) published a final rule of scheduling hydrocodone combination products from Schedule III to Schedule II on August 22, 2014. This rule will go into effect October 6, 2014. This ruling greatly restricts the ability of providers to prescribe hydrocodone products (Lortab, Norco, and Vicodin). This ruling will change our ability to prescribe hydrocodone products and provide refills. We have no control over many of the changes our practice is required to make that may unfortunately affect your postoperative care.

The DEA also strongly recommends the institution of a Medication Monitoring compliance program to ensure adequate protection of our patient's health and decrease drug related mortality and potential abuse or misuse.

The following changes will be put into effect in our practice due to the increased restrictions that accompany this schedule change.
-Schedule II medications (Norco, Vicodin, Lortab, and Percocet) prescriptions must be written on an official prescription form. This means that we will no longer be able to call in prescriptions for this medication. The prescription must be physically picked up from or office.
-We cannot legally provide phone refills on hydrocodone/ oxycodone prescriptions. Patients will be prescribed an adequate supply according to a schedule that will last until their next appointment. No refills will be given between appointments. I a refill is needed an appointment must be made Monday through Friday.
-No "last minute" appointments for refills will be made on Friday's no exceptions will be made.
-If your prescription is lost or stolen, we will be unable to provide you with another prescription until your next scheduled appointment.
-You should expect that narcotic based medications will not be given any longer than six weeks after you last surgery. We will continue to try and treat your pain with non-narcotic modalities after six weeks. If you believe you will require hydrocodone/ oxycodone beyond six weeks, it is advised that you establish care with a chronic pain or primary care physician as soon as possible and notify our clinic that another physician will be assuming care of your pain.
-You may be required to submit to a Medication Monitoring screening during appointments.
-Oral DNA samples may be required to evaluate patient susceptibility to medications.
-If you have a chronic pain physician, it is advised that you make an appointment as soon as possible, as you will not be able to receive the medication from multiple physicians. We will defer to your chronic pain physician for any post operative narcotic prescription.

Should you have any questions or concerns, please contact your Physician or Nurse.

Sincerely,
Wasly Fedoriw, MD

Please sign below to acknowledge receipt of information.

Patient Signature:____Date: ____________________

NOTICE OF PRIVACY PRACTICES

I have reviewed ***ORTHOPAEDIC ASSOCIATES, L.L.P'S*** Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Patient Signature ________________________________ Date ______________

I hereby give authorization to ***Orthopaedic Associates, L.L.P.*** to release any or all of my information regarding my medical records to a designation of my choice:

Name _____________________________________ Relationship to patient ________________

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO Plan.

Patient Signature ________________________________ Date ______________

As your Physician, I believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, I have provided notification that I hold partial ownership interest in:

Memorial Hermann Specialty Hospital
Kingwood

By my signature below, I hereby acknowledge that I have received notification of Dr. Fedoriw's ownership interests.

Patient Signature ____

Orthopaedic Associates, LLP

Surgical Assistant Fee Policy

Orthopaedic Associates, LLP has been in the business of providing quality orthopaedic care since 1950. It is our goal to always provide the best care possible and our staff works very closely with you before your surgery, acting as the liaison and patient advocate with the hospital and your insurance company. We work very diligently to obtain all of the necessary precertification and approvals and talk with you about your estimated out of pocket expenses prior to your surgery. We believe that you will find your experience with our office staff and healthcare providers an excellent one.

With all of the new changes that are occurring with the healthcare system, we have found recent challenges with regarding reimbursements with respect to the surgical assistant fee that we charge. Because of this recent challenge, we have been forced to change our policy with respect to that surgical fee that is charged. Not all insurance companies reimburse for the services provided by that surgical assistant. As the orthopaedic procedure you are about to undergo is a technically challenging one, a well-trained surgical assistant is necessary to provide the highest quality of care and give you the successful surgical results that we have been able to do for more than half a century. Accordingly, we will now collect the surgical assistant fee for our surgical assistant, prior to the surgery. This fee will be $350 for primary procedures, which include joint replacement, joint reconstructive procedures, advanced hand reconstructive procedures, etc., and $600 for revision type surgery, or any surgery where the conditions require additional medical assistance such as obesity or very complex reconstructions.

Customarily, we will bill your insurance company for the assistant fees in an effort to obtain payment. If your insurance company pays all or part of the surgical assistant fee, we will reimburse you for the fee that you paid or a portion thereof.

Our physician assistants are very important to the success of each surgery in which they provide assistance. The assistant fees also encompass the postoperative care, which is considered global, just like the surgeon fees. They are vital to the success of your procedure. They are currently in good standing with the American Academy of Physician Assistants, Texas Academy of Physician Assistants, and National Commission on Certification of Physician Assistants.

Selina Requena, Dr. Fedoriw's secretary is available to go over any questions you may have as a result of this correspondence or any other matter affecting your care. Thank you for your understanding in this manner.

Sincerely,

Wasyl Fedoriw, MD

By signing below, I state that I have read the above policy and agree to pay the surgical assistant fee as described above and further understand that if my insurance company pays the fee I will be reimbursed.

Patient Signature ______________________________ Date ________________

Ortho Trauma One

Surgical Assistants are specially trained medical professionals who assist a surgeon during an operation. The surgeons of our practice commonly used Surgical Assistants during surgery. The surgeons of our practice feel strongly that for many surgical procedures, surgical assistants are a medical necessity. A surgical assistant works with the surgeon as a skilled second pair of hands to maximize safety and efficiency. Potential benefits of surgical assistants include decreased exposure of the surgical site, decreased operative tine and decreased blood loss. Your treating surgeon has determined that the use of a surgical assistant is necessary for you upcoming surgery.

I consent to treatment as deemed necessary and appropriate by the supervising surgeon.

Assignment of Benefits. I certify that the information I have given to Ortho Trauma One, L.L.C ("OTO") is true and correct to the best of my knowledge. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine my medical benefits. I understand that the charges for these services will be billed by the above -named healthcare provider and/or its designated representative.

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for surgical services rendered or provided by the above-named healthcare provider, regardless of its managed network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. Further, I hereby authorize my plan administrator fiduciary, or and/or insurer to release to the above-named healthcare provider any and all Plan documents, summary benefits description, insurance policy, and/or settlement information upon written request from the above named healthcare provider or its designated representative in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above-named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, or health insurance concerning medical expenses incurred as a result of the medical services OTO and/or its designated representative is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefits payments or adverse benefit determinations as defined in 29 CFR 2560-503-1, with the State Insurance Commissioner for possible violation of State Insurance Laws or the Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003 (a) and 114 (a). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I give consent to the release of my medical and financial information contained in my insurance file to OTO or its designated contracted representative and/or business associate, for purposes of filing claims and, when necessary, appealing non-payment by my insurance company, and in all other instances permitted by law. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. I understand that I have the right to revoke this consent in writing, except to the extent that OTO has acted in reliance on it.

If you have any insurance questions, please call our billing representative at 1-800-785-8765. Thank You.

Patient/Guardian Signature: ______________________________

Representative Signature: ______________________________

Date: ______________________________

Ortho Trauma One, LLC
PO BOX 9879
Spring, TX 77387-9879
For Insurance and Billing Questions:
1-800-785-8765

ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

CONSENT FOR RADIOGRAPHS/INJECTION

I, ______________________________ hereby authorize Orthopaedic Associates and staff to perform radiographs of my ______________________________.

I, ______________________________ hereby authorize Orthopaedic Associates and staff to give an injection in my ______________________________.

Signature: ____ Date: ______________

GREGORY P. HARVEY, M.D
VIVEK P. KUSHWAHA, M.D
ALAN J. RECHTER, M.D
NAVIN SUBRAMANIAN, M.D
DAVID L. LIN, M.D.
AMY E. RIEDEL, D.P.M.
WASLY FEDORIW, M.D.

FRACTURE CARE

In the event that our orthopaedic surgeon diagnoses you or your child with a fracture, the treatment of a fracture includes the clinical exam, reading of x-rays, casting/splinting, and following thins injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of the benefits may describe it as a "surgery", but in reality it is not a surgery, but a closed (non surgical) treatment of the fracture.

The charge for this injury is a single charge that includes 90 days for the follow up care, also known as the global period. It does not include charges for x-rays or casting materials. You will not be charged for an office visit every time you visit the doctor since this is included in your initial fracture care exam and fees.

Patient/Guarantor Signature ____________________ Date ____________________

ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

CONSENT FOR TREATMENT

This facility has on staff a physician in the deliver of medical (Orthopaedic) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the Supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/hers education, training, and experience. The services may include:

A. Obtaining histories and performing physical exams
B. Ordering and/or performing diagnosis and therapeutic procedure
C. Formulating and working diagnosis
D. Developing and implementing a treatment plan
E. Monitoring the effectiveness of therapeutic interventions
F. Assisting at surgery
G. Offering counseling and education
H. Supplying sample medications and writing prescriptions (where allowed by law)
I. Making appropriate referrals

I have read the above, and hereby consent to the services of a physician's assistant for my health care needs.

I understand that at any time I can refuse to see the physician's assistant and request to see a physician.

Name (Please Print) ____

Signed ______________________________________ Date________________

ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

Orthopaedic Associates, L.L.P.

I understand Dr. Wasly Fedoriw, M.D. may require a Physician Assistant to assist in my surgery, and in consideration for receiving medical services provided pursuant to my health insurance policy, I assign payment of my insurance benefits directly to Orthpaedic Associates, L.L.P. for the surgical assist services provided.

In the event that my health insurance plan refuses to pay for Physician Assistant surgical assist services, I also assign all my ERISA* rights to a full and fair review process to Orthopaedic Associates, L.L.P. for any and all paid or denied surgical assist claims.

I give consent to release medical information to Othropaedic Associates, L.L.P. or its designated representative. I give consent to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to release medical information to Orthopaedic Associates, L.L.P or its designated representative to send medical information, as necessary, to my insurance plan.

ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed insurance claims according to ERISA regulations.

Patient/ Guardian print name ______________________________

Patient / Guardian Signature ______________________________

Date ______________________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

____
Last First Middle

OTHER NAME(S) USED ______________________________

DATE OF BIRTH Month ________ Day ________ Year ________

ADDRESS ______________________________

____

CITY ______________ **STATE** ______ **ZIP** ________

PHONE (____) __________ **ALT. PHONE** (____) __________

EMAIL ADDRESS (Optional): ______________________________

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name Orthopaedic Associates, L.L.P.
Address 1900 North Loop West, Suite 670
City Houston State Texas Zip Code 77018
Phone (713) 650-6900 Fax (713) 650-4900

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name ______________________________
Address ______________________________
City ______________ State ________ Zip Code ________
Phone (____) __________ Fax (____) __________

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other ______________

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other ______________

Your initials are required to release the following information:

______Mental Health Records (excluding psychotherapy notes)
______Drug, Alcohol, or Substance Abuse Records
______Genetic Information (including Genetic Test Results)
______HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ________ Day ________ Year ________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X______________________________ ______________
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): ______________________________
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other ______________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X______________________________ ______________
Signature of Minor Individual **DATE**

ORTHOPAEDIC ASSOCIATES, L.L.P.
Orthopaedic Surgery & Sports Medicine

Contract for Opioid Therapy

Our policy regarding the prescription of opioids for nonmalignant pain is strict and non negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

Our objective when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, and Norco) for chronic pain conditions.
2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.
3. No refills will be made after clinic hours and on weekends or holidays.
4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship in OA.
5. I will not share my medications with anyone.
6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances an exception will be made (i.e. your house burns down or you have a police report).
7. If my prescription is not refilled, I might experience withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioids withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.
8. While being a patient at OA, I will not receive prescriptions for opioids or other sedatives from any other licensed physician, unless it is authorized by OA. Any evidence of such will result in termination of the patient-physician relationship in OA.
9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship in OA.
10. I will use only **1 (one)** pharmacy to fill my medication.
11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship in OA.

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship in OA.

13. 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 medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in person who has a family or personal history and that of my family to the best of my knowledge.

14. I understand that physical ***dependence*** is normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.

15. I am aware that ***tolerance*** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.

16. I am aware that the use of opioids has been associated with the following side effects:

    - Sleepiness and drowsiness
    - Nausea
    - Vomiting
    - Constipation
    - Urinary retention
    - Dizziness
    - Itching
    - Allergic Reaction
    - Slow breathing/ Slow reflexes and reaction times
    - Low testosterone levels in males

17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.

18. Overdose of this medication may cause ***death*** by stopping my breathing.

19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give ORTHOPAEDIC ASSOCIATES, L.L.P. my consent for the treatment of pain with opioid medications,

20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: ______________________________

Patients Signature: ______________________________ Date Signed: ______________

Pharmacy: ______________________________ Phone #: ______________