

PATIENT NAME:

DOB:

Dear New Patients,

To ensure your appointment is completed in a timely manner, please arrive 15 minutes early and have the following items:

- 1. The completed new patient packet.**
- 2. A valid picture ID and insurance Cards.**
- 3. All co-payments or co-insurances are due at the time of service we accept Cash, Credit, Debit or HSA as forms of payment.**

Should you need to reschedule or cancel your appointment please contact our office at least 24 hours in advance, failure to contact the office will result in a cancellation/ NO show fee of \$26.00.

Please be advised: If you are late, the new patient packet is not completed or you do not have your ID/Insurance cards, your appointment will be rescheduled.

We look forward to seeing you!

Riceland Healthcare

PERSONAL INFORMATION (PLEASE PRINT)

PRINTED PATIENT NAME:			DOB:				
ADDRESS:			CITY:				
STATE:	ZIP:	PHONE:		CELL PHONE:			
SOCIAL SECURITY NUMBER:		ADDRESS:		EMAIL			
OCCUPATION:							
GENDER:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS:	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> SEPARATED
RACE/ETHNICITY:					PREFERRED LANGUAGE:		
<input type="checkbox"/> BLACK	<input type="checkbox"/> CAUCASIAN	<input type="checkbox"/> ASIAN	<input type="checkbox"/> NATIVE AMERICAN	<input type="checkbox"/> HISPANIC			

EMPLOYMENT INFORMATION (PLEASE PRINT)

EMPLOYMENT STATUS:	<input type="checkbox"/> EMPLOYED	<input type="checkbox"/> SELF EMPLOYED	<input type="checkbox"/> STUDENT	<input type="checkbox"/> UN-EMPLOYED	<input type="checkbox"/> RETIRED
EMPLOYER ADDRESS:				CITY:	
STATE:	ZIP:	WORK PHONE:		WORK FAX:	

MEDICAL INSURANCE INFORMATION (IF APPLICABLE)

PRIMARY INSURANCE CO:	MEMBER ID:	GROUP #:
POLICY HOLDER NAME (IF NOT YOU):	POLICY HOLDER SSN#:	DOB:
SECONDARY INSURANCE CO:	MEMBER ID:	GROUP #:
POLICY HOLDER NAME (IF NOT YOU):	POLICY HOLDER SSN#:	DOB:

EMERGENCY CONTACT INFORMATION

NAME:	RELATIONSHIP :	CONTACT INFO:
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PREFERRED PHARMACY

PHARMACY:	PHONE :	ADDRESS:
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PATIENT NAME:

DOB:

CONSENT TO TREAT
Please Initial on each line below

 _____ **PERMISSION TO TREAT**

I give permission for Riceland Healthcare to give me medical treatment. I allow Riceland Healthcare to file for insurance benefits to pay for the care I receive. I understand that Riceland Healthcare will have to send my medical record information to my insurance company. I must pay my share of the costs. I must pay for the cost of these services if my insurance does not pay or I do not have insurance. I understand: I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my clinician.

 _____ **PRESCRIPTION HISTORY CONSENT**

I fully understand the Prescription History access information provided and stated in the New Patient Packet. I voluntarily consent to provide Riceland Healthcare access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years. I acknowledge that Riceland Healthcare may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Riceland Healthcare, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

 _____ **AUTHORIZATION TO DISCUSS MEDICAL INFORMATION**

I understand that by completing the, Authorization To Discuss Medical Information Form, I have Authorize the Use or Disclosure of Protected Health Information (PHI) (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164). Riceland Healthcare may use or disclose PHI as per the terms listed on the Notice of Privacy Practices. The effective period for this permission is from time of this signature moving forward. I understand I have the right to revoke this authorization, in writing, at any time. The PHI are including but not excluded to records relating to mental healthcare, communicable disease, HIV/ AIDS, pregnancies, or treatment of alcohol or drug abuse. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I have read the notice of privacy practices and understand my patient rights regarding my PHI.

 _____ **ONLINE COMMUNICATIONS INFORMED CONSENT-PATIENT PORTAL**

I acknowledge I have received a paper copy of the Riceland Healthcare -ONLINE COMMUNICATIONS INFORMED CONSENT AGREEMENT- PATIENT PORTAL, and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with Online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via Online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

 _____ **ACKNOWLEDGEMENT AND CONSENT FOR RECEIPT OF MARKETING MATERIALS**

I hereby acknowledge and give my explicit consent to Riceland Healthcare to receive marketing materials, including but not limited to newsletters, promotions, and special offers via email. I understand that these communications may contain information about services and products that may be of interest to me. I affirm that I am the owner of the email address provided and have the legal capacity to give this consent. I acknowledge that I have the right to withdraw my consent and unsubscribe from receiving any marketing materials at any time. To opt out of receiving these communications, I can click the unsubscribe link found at the bottom of the email communications. I understand that my decision to receive marketing materials is entirely voluntary and will not affect the quality of healthcare and services I receive from Riceland Healthcare.

 _____ **NOTICE OF PRIVACY PRACTICES**

I acknowledge that the Riceland Healthcare Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Riceland Healthcare cannot be responsible for use or re-disclosure of information by third

_____ I give permission to Riceland Healthcare to discuss any of my medical information with the following individuals:

NAME:	PHONE:	EMAIL:	RELATIONSHIP:
NAME:	PHONE:	EMAIL:	RELATIONSHIP:
NAME:	PHONE:	EMAIL:	RELATIONSHIP:

SIGNATURE OF PATIENT:

DATE:

This Authorization to release medical records expires 1 year after date of signature, and this form will need to be updated.

PATIENT NAME:	DOB:
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

SOCIAL SECURITY NUMBER:	PHONE:
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PATIENT ADDRESS:	CITY:	STATE:	ZIP:
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By signing this form, I request and authorize _____ to release confidential health information about me, By releasing a copy of my medical records to the physician/group listed below:

Release records to: _____

Requesting:

- Last 2 Office Visits from Dr. Ryan McHugh's office*
- All MRI, Cat Scans, and Xrays _____*
- CMP, and Hepatic Function Panel*
- Mental Health records*
- Medication Policy*
- Opioid Risk Tool (ORT)*
- 1 year of Drug Screens results (Confirmations)*
- Medication Contract(s)*
- New patient Referral Records*
- Other: _____*

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding the information. I will not hold Riceland Healthcare liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for their interpretation. I understand the information in my record may include information relating to sexually transmitted diseases, including acquired immunodeficiency (HIV). It may also include information about behavioral or mental health services or treatments for alcohol and drug abuse.

Right to revoke:: I understand I have the right to revoke this authorization at any time. I understand my revocation must be in writing. I understand the revocation will not apply to information already released.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition. (If an expiration date, event, or condition is not specified, this authorization will **expire in 6 months**). Date of Expiration: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:	DATE:
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RELATIONSHIP TO PATIENT:

PATIENT NAME:

DOB:

PATIENT AUTHORIZATION FOR GREATER HOUSTON HEALTHCONNECT


_____ [NAME OF PARTICIPANT] participates in Healthconnect, a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. ("PHI") A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change who gets to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Your treatment and eligibility for benefits will not be affected in any way should you choose not to join Healthconnect.

By signing this Authorization, you agree that Healthconnect and its current and future participants may use and disclose your protected health information electronically through Healthconnect for the limited purposes of treatment, payment and health care operations. You understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect to share your information with those exchanges for the same limited purposes.

This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in Healthconnect. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.

NAME OF PERSON WHO COMPLETED THIS FORM:

DATE:

SIGNATURE:

RELATIONSHIP TO PATIENT:

_____ Initial here if you do NOT want your providers to see your records through Healthconnect

PATIENT NAME:	DOB:
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PAST MEDICAL HISTORY

Please check any illnesses you have had and list the date of onset (approximate dates are acceptable).

CONDITION	DATE	CONDITION	DATE
<input type="checkbox"/> SEASONAL ALLERGIES	_____	<input type="checkbox"/> GERD	_____
<input type="checkbox"/> ANEMIA	_____	<input type="checkbox"/> HEPATITIS (A, B, C)	_____
<input type="checkbox"/> ANGINA	_____	<input type="checkbox"/> HYPERLIPIDEMIA	_____
<input type="checkbox"/> ANXIETY	_____	<input type="checkbox"/> HYPERTENSION	_____
<input type="checkbox"/> ARTHRITIS	_____	<input type="checkbox"/> IRRITABLE BOWEL DISEASE	_____
<input type="checkbox"/> ASTHMA	_____	<input type="checkbox"/> LIVER DISEASE	_____
<input type="checkbox"/> ATRIAL FIBRILLATION	_____	<input type="checkbox"/> MIGRAINE HEADACHES	_____
<input type="checkbox"/> CANCER (TYPE)	_____	<input type="checkbox"/> MI (HEART ATTACK)	_____
<input type="checkbox"/> CVA (STROKE)	_____	<input type="checkbox"/> OSTEOARTHRITIS	_____
<input type="checkbox"/> COPD	_____	<input type="checkbox"/> OSTEOPOROSIS	_____
<input type="checkbox"/> CORONARY ARTERY DISEASE	_____	<input type="checkbox"/> PEPTIC ULCER DISEASE	_____
<input type="checkbox"/> CROHN'S DISEASE	_____	<input type="checkbox"/> KIDNEY DISEASE	_____
<input type="checkbox"/> DEPRESSION	_____	<input type="checkbox"/> SEIZURE DISORDER	_____
<input type="checkbox"/> DIABETES (TYPE 1 OR 2)	_____	<input type="checkbox"/> THYROID DISEASE	_____
<input type="checkbox"/> OTHER	_____	<input type="checkbox"/> OTHER	_____

DRUG ALLERGIES

DRUG:	REACTION:
DRUG:	REACTION:
DRUG:	REACTION:

NO KNOWN DRUG ALLERGIES

PATIENT NAME:

DOB:

FAMILY HISTORY

 UNKNOWN, I am adopted (if you are not aware of your birth's family's medical history, skip the section below)

Has anyone in your family ever has any of the following conditions? (Please indicate if the condition was the cause of death)
CONDITION
FAMILY MEMBER (FATHER, MOTHER, SIBLING, CHILD)

HYPERTENSION

DIABETES MELLITUS

CANCER

HEART DISEASE

ANEMIA

ALZHEIMERS

DRUG ADDICTION

OTHER

SOCIAL HISTORY

SMOKING STATUS
 NEVER SMOKED

 FORMER SMOKER

 CURRENT SMOKER

IF CURRENT SMOKER:

QUANTITY/FREQUENCY: _____

DATE STARTED: _____

IF FORMER SMOKER:

QUANTITY/FREQUENCY: _____

DATE STOPPED: _____

DO YOU USE ANY OTHER TOBACCO OR NICOTINE PRODUCTS?
 NEVER

 FORMER

 CURRENT USER

IF CURRENT: TYPE: _____

QUANTITY/FREQUENCY: _____

DATE STARTED: _____

IF FORMER: TYPE: _____

QUANTITY/FREQUENCY: _____

DATE STOPPED: _____

ALCOHOL CONSUMPTION:
 NONE

 OCCASIONAL

 MODERATE

 HEAVY

TYPE: _____

DATE STARTED: _____

DATE STOPPED: _____

CAFFEINE CONSUMPTION:
 NONE

 OCCASIONAL

 MODERATE

 HEAVY

 COFFEE TEA

 SODA

 ENERGY DRINKS

PATIENT NAME:

DOB:

SURGICAL HISTORY

Please check any surgeries you have had in the past including the date it was done (approximate dates are acceptable)

TYPE OF SURGERY
DATE

ANGIOPLASTY

APPENDECTOMY

ARTHROSCOPY OF KNEE

BACK SURGERY

BREAST BIOPSY

CABG (HEART BYPASS)

CARPAL TUNNEL RELEASE

CATARACT EXTRACTION

CAESAREAN SECTION

CHOLECYSTECTOMY

COLECTOMY

COLOSTOMY

GASTRIC BYPASS / SLEEVE

HERNIA REPAIR

TURP (MALE)

TYPE OF SURGERY
DATE

HIP REPLACEMENT

HYSTERECTOMY

KNEE REPLACEMENT

LASIK (EYE)

MASTECTOMY

MAMMOPLASTY

CARDIAC PACEMAKER

PROSTATE BIOPSY

REDUCTION (BREAST)

ROTATOR CUFF REPAIR

SMALL BOWEL RESECTION

SPINAL CORD STIMULATOR

TONSILLECTOMY

THYROIDECTOMY

VASECTOMY

NAME OF THE PERSON WHO COMPLETED THIS FORM:

DATE:

SIGNATURE:

RELATIONSHIP TO PATIENT:

Patient Name: _____

DOB: _____

Phone Number: _____

Primary Insurance: _____

Preferred Email: _____

Member ID: _____

You are eligible for a new Medicare program that enables us to provide you with services to oversee your chronic conditions and improve your overall wellness. Chronic conditions are ongoing medical problems like diabetes, high blood pressure, dementia, heart disease, depression, osteoporosis, and many others. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further complications or decline in health.

What are the benefits of signing up for Chronic Care Management Services?

- Assistance coordinating visits with your doctors, facilities, labs, radiology, or others
- Regular communication with your care team between your regular scheduled doctors appointment
- Assist with management of medications
- Provide a personalized and comprehensive care plan management
- Assist with scheduling preventive care services, many of which are covered by Medicare

NOTE: You must sign an agreement or provide verbal consent to receive this type of chronic care management services.

What do you need to know before signing up?

Medicare will allow for these services during any month that we have provided at least 60 minutes of non-face-to-face chronic care management services (at least 2 phone calls per month about 30 minutes each)

Our office will have the record of when and how the 30 minutes were spent and you will have access to your electronic medical record if you ever have questions. Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between caregivers directly involved with your health.

You have a right to:

Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form. The provider will continue providing CCM services until the end of the month and may bill Medicare for those services. After the end of the month, the provider will discontinue CCM services and no longer bill for those services to Medicare.

NOTE: Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/ practice.

Beneficiary Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- CCM services will not involve a face-to-face meeting with the Provider phone calls only.

I agree to participate in the Chronic Care Management program. ___ Yes ___ No

I consent to electronic communication including text and Email notifications ___ Yes ___ No

Patient /Client/ Representative: _____

Signature: _____

Date: _____

Authorized Representative/ Reason for Rep Signature: _____ / Reason : _____

Date: _____

Agency Representative: _____

Signature: _____

Date: _____

PATIENT NAME:

DOB:

PLEASE PLACE YOUR INITIAL IN THE BOXES NEXT TO EACH STATEMENT INDICATING THAT YOU HAVE READ AND HAVE A COMPLETE UNDERSTANDING OF THE AGREEMENT.

_____ The purpose of this agreement is to provide you with information about the medications that you are being prescribed and to ensure that you and your clinician comply with all state and federal regulations concerning the prescribing of controlled substances. The goal of your treatment is to provide you with the best possible quality of life given the reality of your clinical condition. The success of the treatment depends on the mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits.

APPOINTMENTS

_____ I will keep all scheduled follow-up appointments. Canceled/Rescheduled and no-show appointments may result in non-renewal of prescription, or if I am given a refill, it will be only a partial prescription. I understand that no additional medication will be sent out until my next appointment. There is no guarantee that appointments will be available before the partial prescription is depleted. No call/no shows are subject to a \$26 fee.

_____ Patients who arrive 15 or more minutes late may be rescheduled to the next available appointment and WILL NOT receive prescription fills that day.

_____ I am REQUIRED TO BRING all medication prescribed by this clinic in their original bottles to EACH scheduled appointment.

MEDICATIONS

_____ I will call the office for ALL prescription requests and renewals during business hours (Monday/Thursday from 8 AM until 4:30 PM). This office does not accept automatic refills and faxed request from pharmacies for any controlled medication. I understand that I may leave a voicemail message for the medication line and that prescription requests will be taken care of within 72 hours from the time of my request, with the exception of weekends and holidays.

_____ Patients who arrive 15 or more minutes late may be rescheduled to the next available appointment and WILL NOT receive prescription fills that day.

_____ I am REQUIRED TO BRING all medication prescribed by this clinic in their original bottles to EACH scheduled appointment.

_____ I agree to take all medication only at the prescribed dose and frequency. I will not increase or change how I take my medication without the approval of the physician. Medication changes and refills will be given only at scheduled appointments.

_____ I understand that this office uses only e-script, an electronic prescription system. No prescription will be called or phoned into the pharmacy by staff members. No exception.

_____ I agree to have all Controlled Medication prescriptions filled only at _____ pharmacy, located at _____. If I must change pharmacies, then I agree that I will do so prior to my medication being sent.

PATIENT NAME:

DOB:

_____ I will always protect my prescriptions and medication. I understand that LOST, MISPLACED, or STOLEN prescriptions WILL NOT be replaced.

_____ Medications prescribed to me are for my use alone. I will not share, sell, or trade with others, and I will not take medication prescribed to anyone else but me. I will keep my medication out of the reach of young children. The provider may require the use of a lockbox for my medication if deemed necessary.

_____ I understand that I may withdraw from this treatment plan and discontinue the use of the medication at any time and that I will notify the physician prior to discontinued use to do so safely. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

COMPLIANCE:

_____ I will not use any substances or drugs considered to be illegal, or that are obtained through illegal means and activities, while under the physician's care.

_____ I understand that there are risks involved in taking illegal drugs and in consuming alcohol while being prescribed controlled medications. Alcohol or illegal drugs taken with controlled medication is NOT permitted. Over the counter medications that cause sedation should NOT be taken with controlled medications.

_____ / agree to random drug screening to be performed at the physician's clinic. This is to ensure that I am taking my prescribed medication and that I am not using any illicit substances or other controlled medications not prescribed by this clinic. I understand that a drug screen is a laboratory test. I understand that I may be requested to supply a urine or saliva sample during my office visit for this purpose.

_____ I understand that I will not receive my prescriptions unless the sample is provided by the end of the scheduled appointment in which the sample was requested. Failure or refusal to do so will result in my dismissal from this office or dismissal from pain medication management.

_____ I understand and accept that my provider can stop prescribing medication if:
I do not show improvement.
My activity level or quality of life has not improved.
I develop rapid tolerance or loss of improvement from treatment. I
develop significant side effects from the medication.
My behavior is inconsistent with the responsibilities outlined
above.

FEMALE PATIENTS ONLY (RISKS OF BIRTH DEFECTS):

_____ To the best of my knowledge, I am NOT pregnant.

_____ The physician has explained all risks that could affect my unborn child should I become pregnant while taking controlled substances. I have also been informed and understand the importance of using safe and effective birth control while taking controlled substances. If I become pregnant, I will notify the physician immediately, I will discuss any controlled medications I am currently taking with my Obstetrician and I will not pick up the controlled medication prescribed until I receive written clearance from my Obstetrician. I understand if the Obstetrician recommends discontinuing a medication my prescribing Physician will place me on a medically supervised tapering program to avoid any possible withdrawal effects or adverse reactions.

_____ Possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/ narcotics/benzos to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

PATIENT NAME: _____

DOB: _____

TO THE PATIENT:

As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your provider for the purpose of this agreement the use of the word "provider" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition

CONSENT TO TREATMENT AND/OR DRUG THERAPY:

I voluntarily request my Provider (name at bottom of agreement) to treat my condition which has been explained to me. I hereby authorize and give my voluntary consent for my Provider to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my condition.

It has been explained to me that the prescribed medication(s) can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and, may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment.

Testing include: Random unannounced checks for drugs, Random Pill counts and Psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests, I Understand my refusal may lead to termination of treatment.

The presence of unauthorized substances may result in my being discharged from your care.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR WITH THE MEDICATIONS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), worsening dementia, Orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work. I understand that I should not take my prescribed medications prior to or during work.

I HEREBY AGREE THAT MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND HAVE A COMPLETE UNDERSTANDING OF THIS AGREEMENT:

Patient Name (print) _____ Date: _____

Name/Relationship to patient: _____ Date: _____

Provider Signature: _____ Date: _____