Advanced Practice
Primary Care

*

*Please review and update the information below to the best of your ability. **

Patient Registration

PLEASE WRITE LEGIBLY

Patient Name: ______________________________________ DOB: ____________________
Last Name First Name

What is your preferred first name? (Nickname, Chosen name, etc) ______________________

Address: ____

City: ____________________________ State: _______________ Zip Code:____________

Phone: ___________________________Email address: _____________________________

Preferred Contact Phone Number: □ Cell □ Home □

SSN: ________________________________ (For your identity privacy at Advanced Practice Primary Care LLC and is used solely for that purpose)

For the purposes of Insurance only, number will be strictly confidential

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Please answer all questions.

What was your assigned sex at birth? What gender do you identify as? What pronoun do you use?

□ Male
□ Female

Interpreter needed? □ Yes □ No Primary Language: _______________________________

□ Hispanic □ Non-Hispanic □ Asian □ Black □ White □ Alaskan Native □ Pacific Islander □ American Indian

Homeless Status? □ Not Homeless □ Homeless □ At Risk □ Transitional Housing □ Living in Shelter

Occupation: ____________________________________ Employer: ___________________

Employment Status (Check one): □ Full Time □ Not Employed □ Part Time □ Retired

□ Seasonal □ Self-Employed □ Student (Full Time) □ Student (Part Time) □ Seasonal

□ Migrant □ Neither

Are you a US Veteran? □ Yes □ No

Primary Care Provider (PCP) Information (Please select one of the following):

□ I wish to establish Primary Care with Advanced Practice Primary Care LLC

□ I see Advanced Practice Primary Care as Adjunctive/Additional Care only:

My Primary Care Physician (PCP) is: ____

□ I do not have a Primary Care Physician and do not wish to establish Primary Care with Advanced Practice Primary Care.

Emergency Contact Name: _______________________ Relationship: __________________

Address: _________________________________ City: ____________________ State_______

Zip: ____________________ Phone: _______________________Legal Guardian? □ Yes □ No

Guarantor (Person who is financially responsible for the account):
Name: ___________________________________ Relationship to the patient: _____________

Address (if different from patient): _____________________________ City: ______________

State:_____ Zip: _________ Social Security Number: ____________ Gender: □ M □ F

DOB: __________________ Guarantor Primary Language: ___________________

Advanced Primary Care Department requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead

of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit.

Please provide your insurance information below:

Insurance Company: ____
Claims Address: ____
Subscriber Name (if other than patient): ____________________ DOB: __________________

Member ID #_______________ Group # _______________ Subscriber ID #_______________

****Please be prepared to present your insurance card at check-in at each visit****

I authorize the following individual(s) to arrange appointments at Advanced Practice Primary Care LLC

Name: ____________________ DOB:________ Relationship to Patient: _________________

Name: ____________________DOB: ________Relationship to Patient: __________________

To the best of my knowledge the above information is complete and accurate.

Signed____ Date:__________

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for Advanced Practice Primary Care LLC

Signed____ Date:_____________

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed____ Date:_____________

I authorize Advanced Practice Primary Care LLC to release medical information required to process my claim

Signed____ Date:_____________

I have read and understand the Financial Policy for Advanced Practice Primary Care LLC

Signed____ Date:_______________

I authorize Advanced Practice Primary Care LLC to obtain/have access to my medication history

Signed____ Date:_______________

I authorize my provider's office to contact me by mobile phone

Signed____ Date:________________

☐ **I have read, understand, and agree to the controlled substance contract for any controlled substances that may be prescribed to me now or in the future.**

Signed____ Date: ________________

Advanced Practice
Primary Care

HIPAA Privacy and Release of Information Authorization

Patient Name:
Patient DOB:

I, ________________hereby authorize Advanced Practice Primary Care and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.
If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

____
Patient Printed Name   Date

____
Patient Signature

775-683-8239
Pauline.stoltzner@APprimarycare.com
APprimarycare.com
6630 S. McCarran Blvd #A12, Reno NV 89509

INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: ____

Other concerns: ____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.______________________	______________________
2.______________________	______________________
3.______________________	______________________

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.__________________	__________________	__________________
2.__________________	__________________	__________________
3.__________________	__________________	__________________
4.__________________	__________________	__________________
5.__________________	__________________	__________________
6.__________________	__________________	__________________
7.__________________	__________________	__________________
8.__________________	__________________	__________________
9.__________________	__________________	__________________
10.__________________	__________________	__________________

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Chickenpox	Date:__________	☐ Meningococcus	Date:__________
☐ Flu Shot	Date:__________	☐ MMR *(Measles, Mumps, Rubella)*	Date:__________
☐ Gardasil/HPV	Date:__________	☐ Pneumonia	Date:__________
☐ Hepatitis A	Date:__________	☐ Tdap *(Tetanus and pertussis)*	Date:__________
☐ Hepatitis B	Date:__________	☐ Tetanus	Date:__________
		☐ Zostavax *(Shingles)*	Date:__________

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date __________ ☐ Abnormal

Last Mammogram Date __________ ☐ Abnormal

Age of first menstrual period: ________

Date of last menstrual period or age of menopause: ______________

☐ Bleeding between periods

☐ Heavy periods

☐ Extreme menstrual pain

☐ Vaginal itching, burning, or discharge

☐ Wake in the night to go to the bathroom

Number of pregnancies: ______ births: _______
miscarriages: ______ abortions: _____________
☐ Cesarean sections If yes, then number: ______

☐ Hot flashes
☐ Breast lump or nipple discharge
☐ Painful intercourse
☐ Sexually active
Current sexual partner is ☐ Female ☐ Male
Do you use condoms ☐ Yes ☐ No
Other Birth control method used:
____
☐ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

☐ Abuse/Domestic Violence
☐ Acid Reflux (GERD)
☐ ADD/ADHD
☐ Allergies/Hayfever
☐ Anemia
☐ Anesthesia Complications
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Autism Spectrum Disorder (ASD)
☐ Back Injury
☐ Bedwetting
☐ Birth Defects or Inherited Disease
☐ Bladder or Kidney Problems
☐ Bleeding Disorder
☐ Blood Clots (or DVT)
☐ Blood Diseases
☐ Blood Transfusion
☐ Breast Cancer
☐ Breast Problem
☐ Cancer
☐ Chicken Pox
☐ Chronic Ear Infections
☐ Claustrophobic
☐ Congenital Anomalies
☐ Congestive Heart Failure (CHF)
☐ Constipation
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Developmental or Behavioral Disorders
☐ Diabetes - Insulin
☐ Diabetes - Non-Insulin
☐ Dialysis
☐ Difficulty Swallowing
☐ Diverticulitis
☐ Ear or Hearing Problems
☐ Eating Disorder
☐ Eczema
☐ Endometriosis
☐ Fibromyalgia
☐ GI Problems
☐ Gout
☐ Has Pacemaker
☐ Head Injury/Concussion
☐ Head Trauma/Injury
☐ Headaches
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Heart Problems
☐ Hiatal Hernia or Reflux Disease
☐ HIV or AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Hospital Admission Other Than Birth
☐ Hospitalizations
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Infertility
☐ Kidney Disease
☐ Kidney Stones
☐ Leg/Foot Ulcers
☐ Lung Disease
☐ Liver Disease
☐ Meniere's disease
☐ Mental Disorder
☐ Mental Illness
☐ MRSA exposure
☐ Muscle, Joint, or Bone Problems
☐ Obesity
☐ Osteoporosis
☐ Ovarian Cancer
☐ Overactive Thyroid
☐ Polio
☐ Polyps
☐ Pre-Eclampsia
☐ Pulmonary Embolism
☐ Reflux or Ulcers
☐ Seizures/Epilepsy
☐ Skin Problems
☐ Stroke
☐ Substance Abuse
☐ Thrombophilias
☐ Thyroid Problems
☐ Tuberculosis
☐ Varicosities
☐ Vision or Eye Problems
☐ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. ____________________	____________________	____________________	____________________
1. ____________________	____________________	____________________	____________________
3. ____________________	____________________	____________________	____________________
4. ____________________	____________________	____________________	____________________

FAMILY HEALTH HISTORY

RELATION **ALIVE? AGE** **SIGNIFICANT HEALTH PROBLEMS**

Grandmother(maternal) Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Grandfather(maternal) Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Grandmother(paternal) Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Grandfather(paternal) Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Father Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Mother Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Brother/Sister Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Brother/Sister Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Other:______ Y/N _______ ☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease
☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Separated ☐ Widowed
☐ Domestic partner

Exercise Level ☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Caffeine ☐ None ☐ Occasional
☐ Moderate ☐ Heavy
\# of cups/cans per day? _____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week?
__

Tobacco Do you use tobacco?
☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes -_____pks./day
☐ Chew - _____/day
☐ Cigars - ______/day
☐ # of years_____
Or year quit ____________

Drugs Do you currently use recreational or street drugs?
☐ Yes ☐ No
If yes, list:
____
____

REVIEW OF SYSTEMS

Please check all that apply:	Ears/Nose/Mouth/Throat	Genitourinary	Neurological
Allergic/Immunologic	☐ Bleeding Gums	☐ Blood in Urine	☐ Dizziness
☐ Frequent Sneezing	☐ Difficulty Hearing	☐ Difficulty Urinating	☐ Fainting
☐ Hives	☐ Dizziness	☐ Incomplete Emptying	☐ Headaches
☐ Itching	☐ Dry Mouth	☐ Increased Urinary Frequency	☐ Memory Loss
☐ Runny Nose	☐ Ear Pain	☐ Urinary Loss of Control	☐ Migraines
	☐		☐

- ☐ Sinus Pressure

Cardiovascular

- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional

- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes

- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:__________

- Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine

- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Hematologic/Lymphatic

- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)

- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

- Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric

- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory

- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

____

____

____

____

______________________________________ ______________________________________

Parent, Guardian, or Caregiver Signature Date

Advanced Practice
Primary Care

Financial Policy Patient Financial Agreement

Advanced Practice Primary Care LLC is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit.

As a courtesy, Advanced Practice Primary Care LLC will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you. For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to Summit Medical Clinic for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits. I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Patient Name: (Print)____

Patient Signature ____

I have read and I understand Advanced Practice Primary Care financial policies and I accept responsibility for the payment of any fees associated with my care.

This is a legally binding contract between Advanced Practice Primary Care LLC and you. The words, I, me, my, you and your all refer to the patient.
_____ (initial) I agree to be financially responsible for payment of Advanced Practice Primary Care LLC. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Advanced Practice Primary Care LLC is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give Advanced Practice Primary Care LLC my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Advanced Practice Primary Care LLC the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour notice was not given. There will be a fee of $30.00 for any missed office visits and $50.00 for any missed office procedures.

_____ (initial) I understand there will be a $25.00 fee for all returned Checks

_____ (initial) I understand that all services provided to me by Advanced Practice Primary Care LLC are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been

approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Advanced Practice Primary Care LLC has a contract with my insurance company. Advanced Practice Primary Care LLC will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Advanced Practice Primary Care LLC my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Advanced Practice Primary Care LLC pursuing any collection means possible.

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____ (initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Advanced Practice Primary Care LLC the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Advanced Practice Primary Care LLC can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit. I have read and I understand Advanced Practice Primary Care LLC financial policies and I accept responsibility for the payment of any fees associated with my care.

____

Patient Signature   Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Advanced Practice Primary Care LLC.

This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document. I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me. I authorize Advanced Practice Primary Care LLC to deposit checks received on my account when made out in my name. I have read and I understand Summit Medical Clinic’s financial policies and I accept responsibility for the payment of any fees associated with my care.

____

Patient Signature Date

Patient Agreement Form

Patient Name:

Agreement for Controlled Prescriptions

The use of____(print names of medication(s)) may cause addiction and is only one part of the treatment for:__________________________________(print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

☐ to improve my ability to work and function at home.

☐ to help my______________________(print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.
- I agree I will not take any illegal substances

Refills

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made**. I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.
The name of my pharmacy is_____________________________________.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your Provider I agree to perform regular checks to see how well the medicine is working.

I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

____________________________________ ______________
Patient's signature Date

____
Provider Signature

☐ This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient's card should be sent to the medical records department and a copy given to the patient.)