CLEVELAND BACK & PAIN MANAGEMENT CENTER

JOHN H. NICKELS, M.D., DIRECTOR

RULES AND CONSENT FOR THE USE OF SCHEDULED MEDICATIONS

I agree by signing below to abide and follow these rules. I also consent and agree to use them as described below. Scheduled Medications are medications such as Narcotics, pain relievers, sleeping pills and some muscle relaxers. I have discussed with Dr. Nickels and/or his partners any questions if my medications are considered controlled or not, and I DO understand whether my medications are controlled or not. I agree, by signing below, to consent to their use to treat my Pain and have discussed benefits, risks and alternative treatment for my pain with Dr. Nickels and/or his partners. I understand the risks of possible addiction, dependency and tolerance may develop with these medications. I understand that there are non-scheduled medications to treat my pain. I also understand that I have the option of being referred to a Chronic Pain Management Program for treatment of my pain or any psychological problems, addictions, depression, etc… I attest by signing below that I have discussed with Dr. Nickels and/or his partners these alternatives and have asked him/her and have had any questions answered about anything I don't understand. I have signed having read and understood everything in this document and do consent to the use of Scheduled Medications and will follow the rules set forth below.

1. I will not lose my prescription or medications, have them stolen, give them to anyone else, launder them, let the dog eat them, etc. As they are the only medications I will get for that time period. I understand that they will not be replaced.

2. I understand that refills will only be given during scheduled office visits and no early refills will be called in for anyone at any time. Please plan ahead to avoid any problems that you might have with the amounts of medication given. If your pain is that bad, go to the emergency room to be checked out.

3. I will come to my regularly scheduled appointment with Dr. Nickels and/or his partners and discuss with him/her my medication usage and any side affects I might be having. I will discuss with Dr. Nickels and/or his partners any problems I am having with Addiction, Dependency or Tolerances. I will let Dr. Nickels and/or his partners know immediately if I am experiencing any Addiction problems.

4. I attest that I am not now nor ever had a problem with Addiction to Scheduled Medications, Alcohol or illegal drugs. If I have had a problem in the past I will let Dr. Nickels and/or his partners know about this immediately. I acknowledge that I am now not addicted to any of the scheduled medications, alcohol or illegal drugs (street drugs, etc.).

5. I will not double up or take anymore medication then prescribed by Dr. Nickels and/or his partners as I understand and know I will run out of medications. I understand that Dr. Nickels and/or his partners never recommend to anyone to double up or take more than the prescribed amount of medication. I will take them only as prescribed and will try to wean off these medications as soon as possible as I understand that drug dependency and addiction are possible. Withdrawal (symptoms) may occur with prolonged usage after they are discontinued.

6. I am aware that these medications may cause sedation, dizziness and occasional euphoria and that I have been advised not to drive cares, operate machinery or expose myself to hazards while on these medications. I also understand if I take more scheduled medications than prescribed they may cause excessive sedation, respiratory depression and/or even death.

7. I understand if there are any indiscretions of these medications whether factual or fiction they must be explored by Dr. Nickels and/or his partners. I understand that a urine drug screen is mandatory and I hereby consent to this test to clear up any problems. I also understand that I might be referred to an Addiction Specialist for his/her opinion. Due to the extreme concern with safety in utilizing these scheduled medications I understand that everything must be cleared up before Dr. Nickels and/or his partners might be able to restart my medications.

8. I hereby attest that I am not receiving any scheduled medications from any other Medical Personnel or Doctors. If it is found that I have received any quantity of scheduled medications from anyone else without reporting this to Dr. Nickels and/or his partners, my medications will be immediately terminated and any remaining refills cancelled.

9. I will report to Dr. Nickels and/or his partners any and every problem that I might have with these medications no matter how small it seems. I understand that Scheduled Medications are an appropriate treatment for Chronic Pain but I must follow these rules to remain on these medications.

I DO HEREBY AGREE TO AND UNDERSTAND ALL OF THE ABOVE. I HAVE RECEIVED A COPY OF THESE RULES AND CONSENTS AND HAVE READ AND UNDERSTAND THEM COMPLETELY. I HAVE ASKED DR. NICKELS AND/OR HIS PARTNERS ANY QUESTIONS I MIGHT HAVE.

PATIENT SIGNATURE	**DATE**	**WITNESS**

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:__________________________ Signature______________________Date________

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.