Indira Gautam, M.D.
327 Iberia St. #3A
Youngsville, LA 70592
Phone: 337-857-3512 Fax: 337-857-3513

PATIENT REGISTRATION FORM

PATIENT INFORMATION ***(Please Print)***

[ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Jr. [ ] Sr. [ ] Other_____

Patient's Name (Last) _____ **(First)** _____ **(Middle)** _____
Also Know as Name (Last) _____ **(First)** _____
Marital Status - [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Legally Separated [ ] Other
Social Security Number _____ - _____ - _____ **Gender** [ ] Female [ ] Male
Date of Birth: _____ **Email Address:** _____
Phone Numbers: Home: _____ Cell: _____
Work: _____ Pager: _____
Address: _____
City, State & Zip: _____
Employment Status: [ ] Employed – {Full-Time or {Part-time} [ ] Full-Time student
[ ] Retired [ ] Self-Employed [ ] Unemployed [ ] Part-Time student
Employer: _____ Occupation: _____
Employer Phone Number: _____
Emergency Contact Name: _____ **Relationship:** _____
Phone Number: _____
Referring Physician Name (If Applicable): _____

RESPONSIBLE PARTY/PRIMARY INSURED'S INFORMATION:
(Please fill in this Section ONLY IF YOU ARE NOT the primary insurance policy holder)
Responsible Party Name (Last) _____ **(First)** _____ **(MI)** _____
Also know as Name (Last) _____ **(First)** _____
Social Security Number: _____ - _____ - _____ **Gender** [ ] Female [ ] Male
Date of Birth: _____ **Email Address:** _____
Phone Numbers: Home: _____ Cell: _____
Work: _____ Pager: _____
Address: _____
City, State, & Zip: _____
Employment Status: [ ] Employed – {[ ] Full-Time or [ ] Part-Time} [ ] Full - Time Student
[ ] Retired [ ] Self-Employed [ ] Unemployed [ ] Part – Time Student
Employer: _____ **Employer Phone Number:** _____
****Patient relationship to Responsible Party:** _____

•Do we have your permission to leave a voicemail on your phone when trying to contact you? Y __ N__
•How did you hear about our practice? _____
••If you were referred by a friend or family member WHO may WE thank you for the referral: _____

**I agree that the information supplied on this form is, and up to date to the best of my knowledge.
Patient (or Responsible Party) Signature_____ Date: _____

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Patient Name: _____ **Today's Date:** _____
Date of Birth:_____ **Age:** _____ **Gender:** _____
Date of last Physical Exam: _____ **What is your reason for today's visit?** _____
_____

Past Medical History

Please check (√) if you have ever been diagnosed with any of the following?		If YES, please tell us when you were diagnosed? Year:
	High Blood Pressure	
	Diabetes	
	High Cholesterol	
	Thyroid Problems	
	Depression	
	Anxiety	
	Cancer Type?	
	Heartburn	
	COPD	
	Have Pacemaker?	
	Other:	

***Please fill out this Medical History Form to the best of your knowledge.**

****Where do you prefer to get your Labs Done?**

**Where do you prefer to get your imaging studies done? (ex. Xrays, CT, MRIs)

****Pharmacy:** (Please list your Pharmacy Name & Address, & Phone Number)_____
_____
_____

Surgeries/Serious Injuries:

Year	Hospital	Type of Surgery of Injury:

Family Medical History:

- **Father: If Living – Age:_____ If Deceased – Cause of Death: _____**
Please list any Medical Problems: _____
- **Mother: If Living – Age: _____ If Deceased – Cause of Death: _____**
Please list any Medical Problems: _____
- **Do you have and blood relatives with the following: If yes: List Relationship to you.**

[ ] Diabetes _____ [ ] Hypertension _____ [ ] High Cholesterol _____
[ ] Heart Disease_____ [ ] Stroke _____ [ ] Genetic Disease _____
[ ] Blood Disorders_____ [ ] Depression _____ [ ] Alcoholism/Drug Abuse_____
[ ] Bipolar Disorder _____ [ ] Cancer: Type _____ Relationship _____
Type _____ Relationship _____
Type _____ Relationship _____

- **Please add any other information about your health that you would like us to know: _____**
_____

Children

Health History (List any illnesses that your children may have)

# of Children	Males	Females:	
	Ages:	Ages:	

Comprehensive Family Care

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Symptoms – Please (√) all the symptoms you CURRENTLY have.

GENERAL
[ ] Chills
[ ] Extreme Fatigue
[ ] Fever
[ ] Night Sweats
[ ] Weight Loss

GASTROINTESTINAL
[ ] Abdominal Pain
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Rectal Bleeding
[ ] Vomiting
[ ] Vomiting Blood

EYE, EAR, NOSE, THROAT
[ ] Bleeding Gums
[ ] Blurred Vision
[ ] Decrease Vision
[ ] Difficulty Swallowing
[ ] Earache
[ ] Hearing Loss
[ ] Hoarseness
[ ] Persistent Cough
[ ] Persistent Nosebleed
[ ] Ringing in Ears

MEN ONLY
[ ] Breast Lump
[ ] Erection Difficulties
[ ] Lump in Testicles
[ ] Penis Discharge
[ ] Sore on Penis
[ ] Other_____

WOMEN ONLY
[ ] Abnormal Pap Smear
[ ] Breast Lump
[ ] Nipple Discharge
[ ] Vaginal Discharge
[ ] Other_____
Date of last menstrual period?_____
Date of last pap smear?_____
Date of last mammogram?

MUSCULOSKETAL
[ ] Joint Pain – Where?_____
[ ] Muscle Ache
[ ] Muscle Weakness

CARDIOVASCULAR
[ ] Chest Pain
[ ] Irregular Heart Beat
[ ] Palpitations
[ ] Swelling
[ ] Shortness of Breath w/Activity
[ ] Syncope

SKIN
[ ] Itching
[ ] Change in Moles
[ ] Rash
[ ] Sore that won't heal

GENITO-URINARY
[ ] Blood in Urine
[ ] Frequent Urination
[ ] Hesitancy
[ ] Painful Urination

Number of Children?_____
Gender_____ Age_____

RESPIRATORY
[ ] Shortness of Breath
[ ] Cough
[ ] Wheezing
[ ] Hemoptysis

NEUROLOGICAL
[ ] Headaches
[ ] Numbness
[ ] Seizures
[ ] Dizziness

PSYCHIATRIC
[ ] Depression
[ ] Anxiety
[ ] Insomnia
[ ] Other _____

HEM/LYMPHATIC
[ ] Swollen Glands
[ ] Blood Transfusion
[ ] H/O Blood Clots
[ ] Bleeding Disorders

ALLERGY/IMMUNOLOGY
[ ] Asthma
[ ] Hives
[ ] Seasonal Allergies
[ ] Irritant Allergies

Social History:
Are you: Single_____ Married_____
Or in a Relationship____ - w/man__ or Woman___
*What is your occupation? _____
*Please (√) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Health Habits
Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other:	

Immunizations – **Are you up-to-date with you immunizations?**
Tetanus: _____ (every 10 years)
Influenza: _____ (Yearly)
Pneumonia: _____
Zostavax: _____ (for patients over 60 years)

Medications: - List all the medications you are currently taking.
_____
_____
_____

Allergies: - Please list any allergies you may have.
_____

**I Certify that the above information is correct to the best of my knowledge, I will not hold my doctor of any member of her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
(Patient's Signature) **Today's Date**

_____
(Reviewed By)

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Patient Consent for Treatment and Payments Agreement

I hereby authorize **Comprehensive Family Care** to use and/or disclose my health information which specifically indentifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations and may include consent at other satellite offices under common ownership.

Treatment includes but is not limited to: the administration and performance of such procedures of all treatments, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedure as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to the authorization of payment directly to **Comprehensive Family Care** of benefits otherwise payable to me. I Hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient's records may be stored electronically and made available through computer networks.

Healthcare operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse there services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for ON the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician (PCP) when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Comprehensive Family Care, all insurances or third party payments that I receive for services rendered to me immediately upon receipt.
Patient Initials: _____

I assign the benefits payable for services to Comprehensive Family Care. I request this authorization also apply to all other insurances. Patient Initial: _____

MEDICARE LIFETIME AUTHORIZATION: I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medial information about me to release to the Social Security Administration of it intermediaries or carries any information needed for this or a relevant Medicare Claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I acknowledge that I have been given **Comprehensive Family Care's** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Office. **Patient Initials: _____**

I certify that I have read and fully understand the above statements and consent fully to voluntarily to its contents.
Patient Name: _____ **Date of Birth:** _____

Responsible Party Signature: _____ Date: _____

Print Responsible Party Name: _____

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Patient HIPAA Acknowledge and Consent Form

Patient Name: _____

Date of Birth: _____

____ (Patient Initials) **Notice of Privacy Practices**. I acknowledge that I have received that practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated to the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practices Notice of Privacy Practices.

_____ (Patient Initials) **Release of Information:** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at any other affiliated facility may be made available to subsequent affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- if I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDs.

Disclosure to Friends and/or Family Members:

I give permission for my protected health information to be disclosed for purposes of communications results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

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AUTHORIZATION AND ASSIGNMENT OF BENEFITS

This form shall release all records necessary to obtain payment for services and assign the benefits directly to **Comprehensive Family Care**. It shall remain in effect until revoked in writing. Revocations cannot be retroactive. This means that you cannot withdraw permission to submit a claim or any documentation or information released in accordance with the below release, after it has been submitted.

Commercial Insurances/ Medigap / Medicaid

I, the undersigned, hereby request any benefits on my behalf, from insurance, Medigap, Medicaid, or any other third-party benefits for health care services provided to me, be paid to **Comprehensive Family Care**. I also authorize the release of any information acquired in the course of my treatment to my insurance company. Medigap, Medicaid, and/or third-party benefit provider, as needed, to issue benefits. If these benefits are not assigned to **Comprehensive Family Care**, I agree to forward all health insurance, Medigap, Medicaid, and other third-party payments I receive for services render to **Comprehensive Family Care**, immediately upon receipt.

Medicare Lifetime Authorization:

HIC#_____ (This is usually the number on your Medicare Card)

**** ʌ(This Highlighted area ONLY needs to be filled out if you have Medicare)****

I certify that the information I am giving in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of any medical or other information about me to the Social Security Administration of its intermediaries or carriers needed to process Medicare claims. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for services to **Comprehensive Family Care** and authorize them to submit a claim to Medicare for me.

I have read, understand, and agree to all of the aforementioned statements as applicable for the **Commercial Insurance/Medicare/Medicaid/Medigap/Third party carrier information for which I have presented.

_____ _____

Print Name Title or Relationship to patient

_____ _____

Patient or (Responsible Party) Signature Today's Date

COMPREHENSIVE FAMILY CARE

DR. INDIRA GAUTAM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	**Birth Date:**	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name: **Dr. Indira Gautam**	**Address/City/State/Zip –** **327 Iberia St. #3A, Youngsville, La 70592**	**Phone Number: (337) 857-3512** **Fax Number: (337) 857-3513**
PHI Sender Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record ☐ History and Physical ☐ Consult Report ☐ Operative Report ☐ Progress Notes		☐ Physician Orders ☐ Laboratory ☐ Imaging/Radiology ☐ Nursing Notes ☐ Medication Record		☐ Demographics ☐ Rehabilitation Services ☐ Special Test/Therapy ☐ Itemized Bill/Claims ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	**Date:**
Print Name of Patient's Representative:	Relationship to Patient:

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Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice.

_____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointments reminders/feedback/health information unless I request a change in writing. (see revocation section below)

The cell phone number that I authorize to receive test messages for appointment reminders, feedback, and general health reminders/information is: _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is: _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation:

I hereby revoke my request for future communications via email and/or text.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email. (NOTE: This revocation only applies to communication from this practice)

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment payment, or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-Up

There may be times when you need a friend or family member to pick-up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to provide a valid picture identification and sign for the prescription.

____ (Patient Initials) I wish to designate the following family member/friend to pick up an order on my behalf:

Name: _____

Name: _____

____ (Patient Initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature:_____ **Date:** _____

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Appointment Policy

Out of respect for your valuable time and that of our other patients, and our staff, we do our best to keep your wait time at or below 15 minutes. In order to accomplish this we ask that you do your part by not being late for your scheduled appointment.

As much as we dislike having to do so, being late for your scheduled appointment may require you to reschedule. If you foresee that you may be late, please call us immediately to be informed if our schedule will allow for tardiness.

We ask that you contact us in advance if you cannot make your scheduled appointment, In order to ensure all patients a timely appointment. If you fail to show for three consecutive scheduled appointments you may not be allowed to reschedule.

I, hereby, acknowledge that I have received a copy of this letter in return after signing.

_____

Patient Name Printed

_____

Patient Signature (or Responsible Party)

_____

Today's Date

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FINANCIAL POLICIES

As your physician, we are committed to giving you the best possible care. To achieve this goal, we need your assistance and understanding our payment policy.

Payments:

- Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes coinsurance and co-payments for participating companies. We accept payments in the form on cash, check, money orders, Visa, MasterCard, Discover, and Debit Cards
- NSF Checks are subject to a $25 check fee in addition to the balance of the check and any fees your bank may charge you. We reserve the right to refuse to accept checks as a payment at any time.

Insurance:

- We bill participating insurance companies on your behalf as a courtesy to you.
- You are **expected to pay your deductible and co-payments at the time of service.**
- If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full.
- If you wish for us to bill your insurance company, your insurance card must be presented at the time of service. If you insurance card or information changes which may be necessary to bill your insurance company, that information must be provided as well at the time of service. Ultimately the patient (or guardian) is responsible for all costs of their healthcare. If your insurance company will not pay for a service or charge which you consent to, you are responsible for the cost associated with those charges.
- We will be glad to discuss your proposed treatment and the costs of those services. We will also attempt to find out if your insurance will cover these services for you. HOWEVER, please be aware that your insurance is a contract between you, your employer (if applicable) , and the insurance company. We are not a party to your contract. Unfortunately not all services are a covered benefit in all contracts. Some insurances companies select certain services that they will not cover (e.g. yearly physicals)
- Insurance companies may request that you release otherwise confidential medical information regarding your condition to them. If you do not authorize the release of this information, we cannot bill your insurance company on your behalf.
- We may refuse to bill an insurance company on your behalf at any time.

Forms/Administrative Time:

- Any form other than the standard insurance forms that you request be completed by our office may be subject to a fee for the time and labor involved. This will be discussed on a case-by-case basis.

****I understand and agree to the financial policy. Furthermore, I understand that intentionally providing false insurance information may constitute insurance fraud and be in violation of federal law.**

_____ _____

Patient Name **Date**

Comprehensive Family Care

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OFFICE POLICIES

APPOINTMENTS

- Comprehensive Family Care is an appointment based practice. Broken appointments represent a cost to us, you, and other patients who could have been seen in the time set aside for you. Cancellations should be requested at least 24 business hours prior to the appointment. Excessive abuse of broken scheduled appointments may result in discharge from our practice. As we try our hardest to see our patients AT their appointment time, we request that you arrive 15 minutes prior to your appointment time to complete any necessary paperwork.
- If you have a child under the age of 18 years, a parent must be present at the time of appointment.
- We strive to treat patients in the most efficient way possible. Follow-up appointments and lab work are vital parts of your healthcare. You comprise your health care and our ability to take the best possible care of you by missing follow-up appointments and lab work. This may serve as grounds for dismissal from our clinic.

ETHICS

- We value you a human being and at all times strive to treat you with respect and dignity. In return we expect you to treat us similarly. Verbal or physical abuse of any employee will not be tolerated and is grounds for dismissal from our clinic.

PAIN MANAGEMENT

- We **DO NOT** prescribe narcotic pain medication for pain management of long-term pain(s), under **any** circumstances. We are more than pleased to refer you to a pain management specialist if you require narcotic pain medication as part of your treatment plan.

PRIVACY

- We have a strict procedure in place to insure your privacy under HIPAA guidelines. Our policies are available to you upon request in our Notice of Privacy Practices packet.
- If you have any questions or concerns, please ask to speak to the Facility HIPAA Compliance Officer or submit them in writing to HIPAA Compliance Officer, 327 Iberia St. #3A, Youngsville, La 70592

SCHOOL/WORK EXCUSES

- Under no circumstances will school/work excuses be issued of the child/parent has not been seen by the doctor or under very limited circumstances; the parent/patient has not spoken with the nurse within the time frame for which the patient/parent is calling.

WORKER'S COMPENSATION AND AUTO INSURANCE

- We do not participate in the treatment of illness in Worker's Compensation claims nor do we handle the initial emergency care from automobile accidents.

****I certify that I have read and fully understand the above statements and consent fully and voluntarily to them**

_____ _____

Patient (or Responsible Party) Signature **Date**

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Policy on Narcotics

Prescriptions

Narcotic pain relieving medications all have the potential to be harmful and addictive. For that reason, this office has a **STRICT POLICY** on such prescriptions. **NO EXCEPTIONS**.

(1.) **WE WILL NOT** refill narcotics prescribed by another physician.

(2.) We will only prescribe narcotics under extreme circumstances, and only after evaluating that patient in the office – **NOT OVER THE PHONE**.

(3.) **WE WILL NOT** refill narcotic prescriptions over the phone.

(4.) **WE WILL NOT** fill lost narcotic prescriptions.

(5.) We will provide alternative non-narcotic pain relieving medications, rather than narcotics.

(6.) **WE WILL NOT** treat chronic, long – standing pain problems as emergencies requiring narcotic pain relieving medications.

***I have read and understand the above statements**.

Print Patient Name: _____

Patient Signature: _____
(Or Responsible Party Signature)

Today's Date: _____