Northeastern Rehabilitation
ASSOCIATES, P.C.

Thank you for choosing Northeastern Rehabilitation Associates

-www.nerehab.com-

To ensure we are providing quality care, we need information from you and need to provide you with information about our practice policies. Our ***New Patient Brochure*** *is enclosed and it outlines our services and practice policies. Please review prior to your visit.*

Please complete the attached ***New Patient Packet*** *in its entirely* ***prior to arriving*** *for your appointment. This information is important for your physician to review with you during your initial visit and if not completed, it may delay your appointment time.*

Many of our patients experience acute and chronic pain. NERA Physicians will work with you to create an effective treatment plan, tailored just for you. Goals of a treatment plan often include reducing pain, maximizing your ability to perform functions of daily living and to help improve your quality of life. Patient Health Questionnaires are tools used to assist in creating your treatment plan. Please complete the enclosed, ***SOAPP-14*** *questionnaire and bring with you to your first visit. You may be asked to update this information annually or more often as your treatment plan changes over time.*

To provide you with secure electronic access to our physicians and staff, Northeastern Rehabilitation Associates utilizes a ***Patient Portal****. Instructions for access are included in this packet. You can request appointments, update your medical history, medications, allergies, and send a note to your provider. Your provider may send forms for you to complete as part of your treatment plan via the Portal as well.*

We encourage you to sign up for the Patient Portal before your first visit.

Revised 11/9/18

IMPORTANT

It is very important that the attached Medical Record Authorization form
be completed and returned to us ***before your visit.***

PLEASE DO NOT SEND THE ENTIRE PACKET BACK – JUST THE AUTHORIZATION FORM. BRING THE COMPLETED PACKET WITH YOU ON THE DAY OF YOUR APPOINTMENT.

Many medical offices will not forward your medical office notes or imaging to us without a signed authorization. If your NERA provider does not have your prior medical records at the time of your initial visit he/she will not be able to fully implement a treatment plan for you.

You may return this form to us by any of the following methods:

For all office locations:
Scan and email to MR@nerehab.com
Note: This address is only for Medical Record Authorization forms.
No other communication will be addressed.

\- or -

Scanton Office or Carbondale Office:

Scranton Office or Carbondale Office:
Attention Medical Records
Drop off/Mail to:
5 Morgan Hwy- Suite 4- Scranton PA, 18508
Fax: 570-558-6361

Wilkes-Barre Office:
Attention Medical Records
Drop off/Mail to:
150 Mundy Street, Mac IV, Wilke-Barre, PA 18702
Fax: 570-270-6279

Bethlehem Office:
Attention Medical Records
Drop off/Mail to:
3400 Bath Pike, Bethlehem, PA 18017
Fax: 484-895-3187

Northeastern Rehabilitation
ASSOCIATES, P.C.

LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM
(Please print all information. Form must be signed and dated each year).

Patient Name: ____

SSN (last four digits): ______________________________ **Date of Birth:** ____________________________

Entity Requested to Release Information: ____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information:

☐ Northeastern Rehabilitation Associates, PC, 5 Morgan Highway, Suite 4 Scranton, PA 18508
☐ Northeastern Rehabilitation Associates, PC, 150 Mundy Street, MAC IV, Wilkes-Barre, PA 18702
☐ Northeastern Rehabilitation Associates, PC, 3400 Bath Pike, 4th Floor, Suite 400, Bethlehem, PA 18017

- Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
☐ office notes
☐ lab results, pathology reports
☐ x-rays;
☐ financial history report
(previous 3 years only)
☐ nursing home, home health, hospice, and other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only send the following: ___________________________________

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request ☐ Other (please specify):

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: __________________

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

____ ____________________________
Patient or Representative Signature Date

____ ____________________________
Patient or Representative Signature Date

____ ____________________________
Patient or Representative Signature Date

____ ____________________________
Patient or Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.

Patient Information Sheet *(Please Print)*

Patient Name: ____
Last First Middle I

Date of Birth: _____ / _____ / ______ **Soc. Sec. # :** ________ / ______ / ___________ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other ______________________________

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language**:_______________________

Home #: ______________________ **Cell #:** ________________________ **Work #:**________________________

Address: ____

City: ____ **State:** ___________ **Zip:** ________________

Referring Physician: _______________________________________ **Phone:** _________________________

Primary Care Physician: ____________________________________ **Phone:** _________________________

Emergency Contact____ **Phone:** _________________________

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: ____ **Relation:** _____________________________

■ **Primary Insurance Company:** ____

Insurance ID # : ___________________________________ **Group # :** __________________________________

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: ____ **Date of Birth:** _____ / _____ / _______
Last First Middle I.

Relationship to Patient: ____________________________________ **Soc. Sec. #** _______ / _______ / _________

Address: ____

City: ____ **State:** ___________ **Zip:** ________________

Home Phone _________________________________**Work Phone** _______________________________________

Employer: ____

■ **Secondary Insurance Company:** ____

Insurance ID # : ___________________________________ **Group # :** __________________________________

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: ____ **Date of Birth:** _____ / _____ / _______
Last First Middle I.

Relationship to Patient: ____________________________________ **Soc. Sec. #** _______ / _______ / _________

Address: ____

City: ____ **State:** ___________ **Zip:** ________________

Home Phone _________________________________**Work Phone** _______________________________________

Employer: ____

PLEASE COMPLETE THIS SECTION IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT

Patient Name: ____________________

■ **Work Related Injuries**

Date of Injury: ______ / ______ / ______ **Claim #:** ____________________

Employer: ____________________ **County located in:** ____________________

Address: ____________________

City: ____________________ **State:** __________ **Zip:** __________

Phone: ____________________

Contact Name: ____________________ **Phone:** ____________________

Address where Injury Occurred- if different than address above:

City: ____________________ **State:** __________ **Zip:** __________

Job Title: ____________________ **Usual Job Duties:** ____________________

■ **Auto Accident**

Date of Injury: ______ / ______ / ______ **Claim #:** ____________________

State where Injury Occurred: __________

Auto Insurance Carrier: ____________________

Insurance ID # : ____________________

Address: ____________________

City: ____________________ **State:** __________ **Zip:** __________

Phone: ____________________

Contact Name: ____________________ **Phone:** ____________________

■ **Attorney Information - if Applicable**

Name: ____________________

Address: ____________________

City: ____________________ **State:** __________ **Zip:** __________

Phone: ____________________

PATIENT PAIN HISTORY:

Patient Name: ___________________________________ **Date of Birth:** ____________ **Age:** ________

1. Which is your dominant hand? ☐ Left ☐ Right ☐ Ambidextrous
2. What is your main complaint?____
   ____
   ____
3. Is this the result of a Work Injury? ☐ No ☐ Yes **If yes**, date of injury: ______/_____/______
   Describe this incident: ____
   ____
   ____
4. Is this the result of a Motor Vehicle Accident? ☐No ☐ Yes **If yes**, date of accident: _____/____/_____
   Describe this incident: ☐ Head-On ☐ Rear-Ended ☐ T-Boned ☐ Other__________________________
   ____

☐ Driver ☐ Passenger Front Seat ☐ Passenger Back Seat	☐ Loss of consciousness ☐ Airbags deployed ☐ Seatbelt	☐ Ambulance: ☐ C-Collar ☐ Backboard Name of ER: _________________

5. If you answered NO to questions 3 and 4, please describe when and how your illness or injury occurred:
   ____
   ____
6. Have you had anything similar before? ☐ No ☐ Yes **If yes,** please explain:
   ____
   ____
7. Prior to this episode, were you completely symptom free? ☐Yes ☐ No **If no**, please explain:
   ____
   ____
8. What doctors have you seen for this problem?____
   ____
9. TESTING
   Which of the following tests have been done for your condition?
   ☐ X-ray* Date:_____/_____/________ Facility ___________________________________
   ☐ MRI* Date:_____/_____/________ Facility ___________________________________
   ☐ Cat Scan* Date:_____/_____/________ Facility ___________________________________
   ☐ Bone Scan* Date:_____/_____/________ Facility ___________________________________
   ☐ EMG Date:_____/_____/________ Facility ___________________________________
   ☐ Other: ____________________________ Date:____/_____/______ Facility ____________________

*** Please bring any/all X-rays, MRIs, and Medical Records that may pertain to your current problem/injury.**

Patient Name: ____

10. Please review the pain scale below. Indicate by answering **0-10** which best describes your pain level:
a. Current pain level:______ **b.** Past 30 days, pain at its best:______ **c**. Past 30 days, pain at its worst: _____

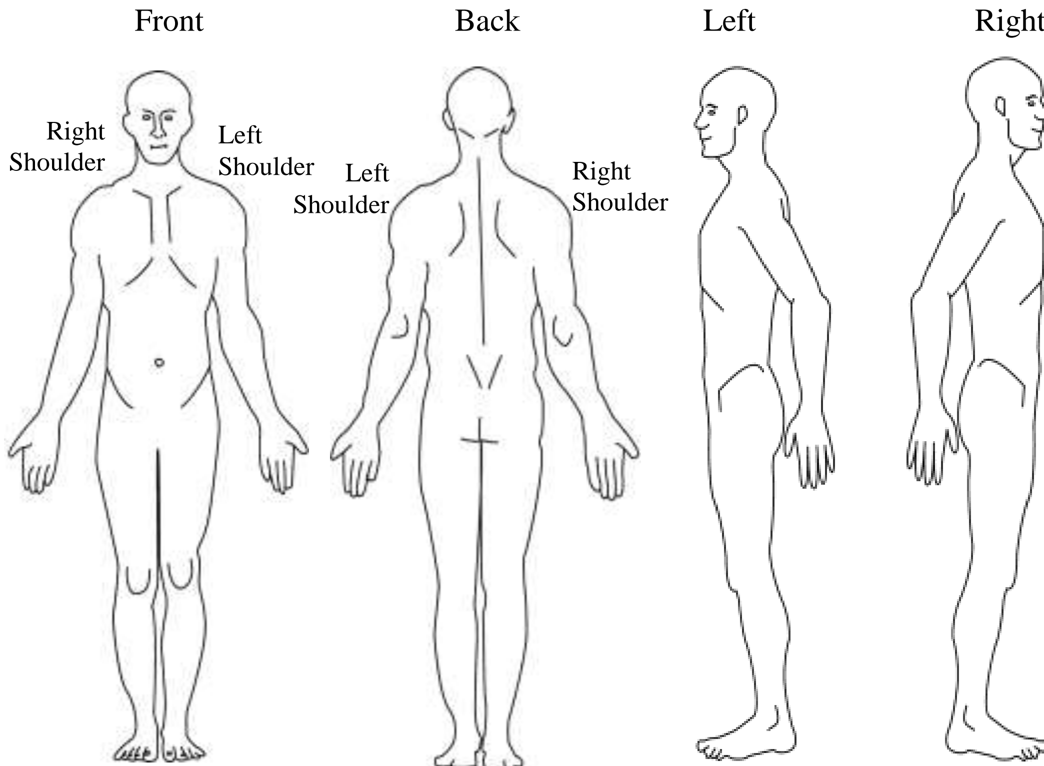
0	**No Pain**	I have no pain
1	**Minimal**	My pain is hardly noticeable
2	**Mild**	I have a low level of pain, I am aware of my pain only when I pay attention to it
3	**Uncomfortable**	My pain bothers me but I can ignore it most of the time
4	**Moderate**	I am constantly aware of my pain but I can continue with most of my activities
5	**Distracting**	I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.
6	**Distressing**	I think about my pain all of the time. I give up many activities because of my pain.
7	**Unmanageable**	I am in pain all the time. It keeps me from doing most activities
8	**Intense**	My pain is so severe that it is hard to think of anything else. Talking and listening are difficult.
9	**Severe**	My pain is all that I can think about. I can barely talk or move because of the pain.
10	**Unable to Move**	I am in bed and can't move due to my pain. I need someone to take me to the emergency room to get help for my pain.

11. How frequent is your pain? ☐ Constant ☐Intermittent Explain______________________
12. How long does your pain last? ☐ Less than 1 hour ☐ Less than 1 day ☐All day ☐All night
13. Is your pain getting: ☐ Better ☐ Worse ☐ Not changing

	Worsens Pain	**Relieves Pain**	**No Effect on Pain**		**Worsens Pain**	**Relieves Pain**	**No Effect on Pain**
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/Sneezing			
Bending forward				Lying on your side			
Bending backward				Lying on your back			
Bending to the side				Lying on your stomach			

USE THE FOLLOWING SYMBOLS TO INDICATE ON THE DRAWING EXACTLY WHERE YOUR PAIN IS AT THE PRESENT TIME.

Burning (X) **Numbness (O)** **Pins/Needles (=)** **Stabbing (/)** **Ache (^)** **Throb** (V)



Patient Name: ____

1. Have you had any Physical Therapy in the past 2 years? ☐ No ☐ Yes
   If yes, please indicate the following:

   a. Body Part Treated: ___________________________ Facility:_____________________________
   When (Month/Year): _________________________ How Long: __________________________

   b. Body Part Treated: ___________________________ Facility:_____________________________
   When (Month/Year): _________________________ How Long: __________________________

2. Please check next to any other treatments you have had for your **present** injury:

   ☐ Ice/Heat: Helpful? Yes ☐ No ☐
   ☐ Anti-inflammatory Medications (NSAIDs) including over the counter Advil, Aleve, etc.
   When? ____________ / How Long?___________ Helpful? Yes ☐ No ☐

   ☐ TENS/ E Stim: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Traction: Helpful? Yes ☐ No ☐ Also, do you have a unit for home use? ☐Yes ☐ No
   ☐ Exercises: Helpful? Yes ☐ No ☐
   ☐ Acupuncture: Helpful? Yes ☐ No ☐
   ☐ Massage: Helpful? Yes ☐ No ☐
   ☐ Chiropractic: Helpful? Yes ☐ No ☐
   ☐ Injections: Helpful? Yes ☐ No ☐ What type of injection?______________________________
   When was your last injection? ________________________
   ☐ Bracing: Helpful? Yes ☐ No ☐
   ☐ Psychological Treatment: Helpful? Yes ☐ No ☐

3. With respect to your pain, how are you feeling now compared to before you received treatment?

   ☐ Very Much Worse ☐ Much Worse ☐ Minimally Worse ☐ No Change
   ☐ Minimally Improved ☐ Much Improved ☐ Very Improved

PAST MEDICAL HISTORY:

Do you or have you had any problems with the following: (Check all that apply)

☐ Alcohol Abuse
☐ Arthritis (Osteoarthritis)
☐ Arthritis (Rheumatoid)
☐ Asthma
☐ Cancer
Type: ________________
☐ Cholesterol
☐ Diabetes
☐ Fibromyalgia
☐ GERD (Reflux)
☐ Heart Disease
☐ Drug Abuse ☐ Prescription drugs ☐ Street drugs
☐ Hepatitis
☐ HIV/AIDS
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Stroke/ TIA
☐ Thyroid
☐ Anxiety
☐ Depression

☐ Other: ____

☐ Past Work Injury – Date: _____________ ☐ Past Motor Vehicle Accident – Date: _____________

PLEASE LIST SURGERIES YOU HAVE HAD: **DATE:**

____ ____________________________

____ ____________________________

____ ____________________________

Patient Name: ____

FAMILY HISTORY: Please check any diseases/disorders that run in your family. **Do not include yourself**.

	Relative		**Relative**		**Relative**
☐ Heart disease	____________	☐ Arthritis	____________	☐ Hypertension	____________
☐ Alcohol Abuse	____________	☐ Diabetes	____________	☐ Drug Abuse	____________
☐ Cancer	____________	☐ Other	____________		

SOCIAL HISTORY:

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_________
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_________ Per week?_________
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? ____

EMPLOYMENT STATUS:

1. Job Title/Occupation: ____
2. Briefly describe your job duties: ____
3. Are you currently under work restrictions ☐ No ☐ Yes **If Yes,** what are your restrictions?
   ____
4. Please check current work status:
   ☐ Working Full Time: Hours worked per day______ Days worked per week _______ Shift________
   ☐ Working Part Time: Hours worked per day______ Days worked per week _______ Shift_________
   ☐ Working Light Duty: Hours worked per day______ Days worked per week _______ Shift_________
   ☐ Off Duty Due to Injury: Date last worked: __________________
   ☐ Retired/Not Working

ACTIVITIES OF DAILY LIVING: Please check the level you are presently able to complete the following activities:

	Independent	**Need some Assistance**	**Unable**		**Independent**	**Need some Assistance**	**Unable**
Walk	☐	☐	☐	Feed yourself	☐	☐	☐
Dress	☐	☐	☐	Clean your house	☐	☐	☐
Bathe	☐	☐	☐	Care for your family	☐	☐	☐
Drive	☐	☐	☐				

1. Please list up to four things in your life that you can't do or have difficulty with because of your pain and which most dearly you want restored? These should be simple, realistic daily life improvements that other people can see most of the time.
   ______________________________ ______________________________
   ______________________________ ______________________________
2. Are there other limitations due to current condition?____________________________________
3. At one time, how long can you: Sit ________________ Stand__________________ Walk_____________
4. Do you use any of the following? ☐ Straight cane ☐ Quad cane ☐ Walker ☐ Wheelchair
   Prior to your injury/illness was your ability to do things at all limited? ☐No ☐Yes
   If yes, please explain: ____
5. Are there stairs to enter/or in your home? ☐ No ☐ Yes How many? ____ Is there a rail? ☐ Yes ☐ No

Patient Name:____

Review of Systems

Do you have problems with any of the following? Please check all that apply.

General
- ☐Fatigue
- ☐Weakness
- ☐Trouble sleeping

Skin
- ☐Rashes
- ☐Dryness
- ☐Color changes
- ☐Hair/nail changes

Head
- ☐Headache
- ☐Head Injury

Eyes/Ears/Nose/Throat
- ☐Blurry or double vision
- ☐Eye pain
- ☐Blindness
- ☐Ear pain
- ☐Ringing in ears
- ☐Deafness
- ☐Nose bleeds
- ☐Dry mouth
- ☐Sore throat/hoarseness
- ☐Non-healing sores

Neck
- ☐Stiffness
- ☐Swollen glands
- ☐Pain

Cardiac
- ☐Palpitations
- ☐Chest discomfort at rest
- ☐Chest discomfort with activity

Respiratory
- ☐Wheezing
- ☐Shortness of breath with normal activity
- ☐Shortness of breath with exertion
- ☐Cough- wet, dry or productive
- ☐Coughing up blood

Circulation
- ☐Discoloration of feet/legs
- ☐Sores/ulcers on feet/legs
- ☐Swelling of ankles/legs
- ☐Calf pain with walking
- ☐Leg Cramps
- ☐Varicose veins

Gastrointestinal
- ☐Difficulty swallowing
- ☐Heartburn
- ☐Unexplained nausea/vomiting
- ☐Change in bowel habits
- ☐Constipation
- ☐Diarrhea
- ☐Blood in stool
- ☐Loss of bowel control
- ☐Abdominal pain

Genitourinary
- ☐Frequent urination
- ☐Painful urination
- ☐Loss of bladder control

Musculoskeletal
- ☐Muscle or joint pain
- ☐Stiffness
- ☐Back pain
- ☐Redness of joints
- ☐Swelling of joints
- ☐Trauma

Nervous System
- ☐Dizziness
- ☐Fainting
- ☐Seizures
- ☐Numbness/Tingling

Metabolism/Endocrine
- ☐Heat or cold intolerance
- ☐Excessive sweating
- ☐Increased thirst
- ☐Change in appetite
- ☐Recent unexplained weight changes

Hematology
- ☐Unexplained fevers
- ☐Ease of bruising
- ☐Ease of bleeding

Psychiatric
- ☐Nervousness
- ☐Memory loss
- ☐Stress
- ☐Bipolar Disorder
- ☐Other psychological diagnosis _______________

Women Only
- ☐Currently pregnant
- ☐Breastfeeding
- ☐Date of last menstrual period ____/____/______

Reviewed By:

____

Date: _____/_____/_______

Patient Name: ____

MEDICATION INTAKE SHEET

Please list **ALL** medications taken on a daily basis, including **vitamins, herbals and over-the-counter medications**. Please list all **medication allergies.**
Please list pharmacy name and telephone number.

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: ____________________________ Who Prescribed: ____________________________

Medication: ____________________________ Who Prescribed: ____________________________

Medication: ____________________________ Who Prescribed: ____________________________

Medication: ____________________________ Who Prescribed: ____________________________

Medication: ____________________________ Who Prescribed: ____________________________

MEDICATION ALLERGIES:
____

____

Pharmacy Name ________________________________ **Phone Number**______________________

Northeastern Rehabilitation
ASSOCIATES, P.C.

Screener and Opioid Assessment for Patients with Pain- SOAPP V1- 14Q

As part of your treatment plan with your Northeastern Rehabilitation Associates (NERA) physician, you may receive a prescription for a controlled substance medication. In addition to medication agreements and random drug screen protocols, NERA requires a medication screening form to be completed by all patients receiving these medications. **Your health insurance may also require a pre authorization of this medication before it can be filled by your pharmacy. The pre authorization process also requires the completion of this form.**

Name: ______________________________________ **Date of Birth:** _______________ **Date:** __________

Please Print

The following are some questions given to all patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Please answer the questions below using the following scale: (Circle answer)

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

	Question	Answer
1.	How often do you have mood swings?	**0 1 2 3 4**
2.	How often do you smoke a cigarette within an hour after you wake up?	**0 1 2 3 4**
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	**0 1 2 3 4**
4.	How often have any of your close friends suggested that you have a drug or alcohol problem?	**0 1 2 3 4**
5.	How often is there tension in the home?	**0 1 2 3 4**
6.	How often have you attended an AA or NA meeting?	**0 1 2 3 4**
7.	How often have you taken medication other than the way it was prescribed?	**0 1 2 3 4**
8.	How often have you been treated for an alcohol or drug problem?	**0 1 2 3 4**
9.	How often have your medications been lost or stolen?	**0 1 2 3 4**
10.	How often have others expressed concern over your use of medication?	**0 1 2 3 4**
11.	How often have you felt a craving for medication?	**0 1 2 3 4**
12.	How often have you been asked to give a urine screen for substance abuse?	**0 1 2 3 4**
13.	How often have you used illegal drugs (example marijuana, cocaine, etc) in the past five years?	**0 1 2 3 4**
14.	How often, in your lifetime, have you had legal problems or been arrested?	**0 1 2 3 4**

Please include any additional information you wish about the above answers. Thank you.

NERA Medication Agreement/Refill Policy

Your treatment plan with NERA may include diagnostic and/ or therapeutic interventions, behavioral medicine, alternative therapies, physical therapy and use of prescription medications. Medications can have serious side effects if they are not managed properly. Your health and safety are very important to us. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship. You will receive information from your NERA physician regarding the risks and potential benefits of these medications and you should address any concerns regarding your medication regimen with your NERA physician.

Please read each statement and sign below. If you have any questions regarding this information or practice policy regarding the prescribing of controlled substances, please request clarification from your NERA physician. If you would like a copy of this Agreement for your records, please ask the staff to provide you with a copy during your visit.

You acknowledge that you:

1. Understand the main goal is to improve your ability to function /work and to reduce pain. You agree to comply with the treatment plan as prescribed by your NERA physician. In addition to utilizing pain medications, other medical treatments, following better health habits such as exercise, weight control and avoiding the use of nicotine and alcohol, may be part of your treatment plan. You understand that it may not be possible to completely eliminate all of your pain.

2. Understand that your medication regimen may be continued for a definitive time period as determined by your NERA physician. Your treatment plan will be reviewed periodically. If there is no significant evidence of improvement or progress being made to improve your functioning or quality of life, the regimen may be tapered or possibly discontinued and your care referred back to your primary care physician.

3. Understand you must inform your NERA provider of **all** medications you are taking, including over-the-counter, herbals, and vitamins, as controlled substances can interact with other medications.

4. Understand that you must notify your NERA physician if you have a history of alcohol and/or drug misuse/addiction, as treatment with controlled substances may increase the possibility of relapse.

5. Understand that there are potential side effects and interactions involved with taking any medication, including the risk of addiction. Possible complications include but are not limited to: constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration and reduced sexual function. You may develop a tolerance, and become physically dependent on the medication. You must notify your NERA physician if you experience any adverse effects with your prescribed medications.

6. Understand that opioid medications can cause physical dependence within a few weeks of taking these medicines. If you suddenly stop or decrease the medication, you could experience withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hour of the last dose. Do not stop these medications without consulting your NERA physician.

7. Understand that the use of alcohol while taking controlled substances is contraindicated.

8. Agree to take the medications only and **exactly** as prescribed by your NERA physician.

9. (Female patients only) Understand that if you plan to get pregnant or believe that you have become pregnant while taking these medications, you will immediately call your Obstetric and NERA physicians to inform them. Understand that many medications could harm the fetus or cause birth defects.

10. Understand that you must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, making it unsafe to drive or operate heavy machinery. If there is any question of your ability to safely perform these activities, you will not attempt to perform the activity until the side effects have had time to resolve.

11. Agree to use only <u>one</u> pharmacy for your pain-related medications. In the event that circumstances require the use of another pharmacy, you will notify NERA of this immediately and provide all pertinent contact information.

12. Understand that NERA does not replace lost or stolen prescriptions or medications or those destroyed by fire, flood, etc. The safekeeping of your medication and prescriptions is your responsibility. This includes keeping medications out of reach of children. You will not share, sell, exchange or otherwise permit others to have access to these medications for any reason.

13. Agree that you will not seek or accept any pain medications other than those prescribed by my NERA physician. This includes prescriptions for pain medications from other physicians, medication borrowed or accepted from family or friends and any illicit or street drugs. If you are in an emergent situation, have surgery, a dental procedure, etc., and are given a controlled substance by another physician, you must notify your NERA physician as soon as possible. You consent to the disclosure of all personal health information related to this matter.

14. Agree that you will not use any illegal substance, (cocaine, heroin, marijuana, etc) while being treated with controlled substances. Using illegal substances will result in a change to your treatment plan, including the safe discontinuation of controlled substances when applicable or may result in the termination of the doctor/patient relationship. * If you are being prescribed *medical* marijuana, you must provide your NERA physician with verification before any controlled substances will be prescribed. Understand that medical marijuana is only legal at the state level and not at the federal level. Physician DEA licenses are registered at the federal level and may choose NOT to prescribe opiates to patients with positive marijuana screens despite PA law.

15. Agree to keep all scheduled appointments. Most patients taking controlled substances will need to be seen at least every one to three months. You understand that no medication prescriptions/refills will be given for canceled or no-show appointments. You understand that if you are 15 minutes late for an appointment time, you will be rescheduled for another appointment and no prescriptions/refills will be given. Scheduled appointments are required for all office visits. NERA physicians do not see “walk-in” patients.

16. Understand that each prescription is for a specific number of pills, designed to last a certain amount of time. Early refills will not be given. It is not our practice to make changes to your prescriptions by telephone. New prescriptions, changes to prescriptions or medication refills will not be addressed after office hours, on weekends, or on holidays. If you are experiencing concerns with your medications, you will be scheduled for an office appointment. Medical Assistants phone triage hours are from 9AM- 4:00PM, Monday through Friday for refill requests and questions. Medical Assistants are assisting the doctors during the day and may not be able to speak with you directly at the time of your call. Please leave detailed information and you will receive a call back before the end of the business day.

17. Understand that your NERA Provider is required to check your prescription history via the state database, *PA Aware,* every time you are prescribed a controlled substance and with medication refills.

18. Understand that you may be asked to bring any or all of your prescribed medicines to the office at a random time or at your office appointment, for a prescription compliance check (Pill Count). Understand that failure to comply with or discrepancy with pill counts may result in the discontinuation of medication prescriptions and you may be discharged from the practice immediately.

19. Understand that you will undergo random urine drug screens as long as your treatment plan utilizes controlled substances. You accept responsibility for the cost of the urine drug test in the event that your healthcare coverage will not cover the cost of this test. If the results of the urine drug screen do not reflect medicine prescribed by your physician, or you test positive for illegal substances, you understand this may result in the discontinuation of medication prescriptions and you may be discharged from the practice immediately.

20. Understand that altering a prescription in ***any*** way is against the law. Report of forged, falsified, or altered prescriptions will result in your immediate discharge from NERA. NERA cooperates fully with law enforcement agencies in regards to infractions involving prescription medications. Understand that if the responsible, legal authorities have questions regarding your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

21. Understand that inappropriate, abusive behavior or harassment of any NERA staff member will not be tolerated.

22. Understand that NERA physicians may discontinue any prescriptions, and discharge you from the practice if any of the following occurs:
    - You give, sell, or misuse your pain medication, including but not limited to: taking more medication than prescribed, running out of medication early, obtaining medications at more than one pharmacy,
    - You fail to keep follow- up appointments,
    - You attempt to obtain pain medication after office hours, on the weekend, on holidays, from any other physician, or any other source,
    - You do not cooperate with requested Pill Counts or Urine Drug screens, or there is any discrepancy with results of Pill Counts and/or Urine Drug Screens.
    - You are released from the practice for any reason,
    - Any aggressive behavior toward NERA staff or physicians,
    - Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of your NERA physician.

By signing this document you acknowledge that:

- You have thoroughly read, understand and accept all the above statements.
- You have received and understand the NERA Prescription Refill Policy.
- You agree to adhere to the terms of this Medication Agreement and the NERA Prescription Refill Policy, knowing that failure to do so may result in termination of treatment with all NERA providers.
- This agreement is in effect for the duration of your treatment.
- Your NERA physician may provide a copy of this agreement to your pharmacy, referring physician and all other physicians involved in your care.

Patient Signature ____ Date _____/______/_______

Patient Name ____ Date of Birth _____/_____/_____
(Please Print)

Pharmacy Name: _________________________________ **Phone#** ______ / ______ / ___________

If you change your pharmacy for any reason, you agree to notify this office at the time you receive a prescription.

Reviewed by Physician/Staff Signature _______________________________ Date____/____/____

6/04,/7/05,7/10,9/17