REGENCY
PAIN & THERAPY INSTITUTE

74 Regency Parkway, Mansfield, TX 76063 • Phone: (817) 419-6111 • Fax: (817) 419-9582

NEW PATIENT PACKET - WELCOME TO REGENCY

Who are you here to see today?

☐ Jason Butler, M.D.
☐ Mark Dirnberger, D.O. ☐ Other: _____

How did you hear about us? (please specify)

☐ Website/Advertisement ☐ Physician Referral: _____
☐ Friend / Family ☐ Other: _____

Patient Information

Name (First, Middle, Last) | Social Security # | Date of Birth | ☐ Male ☐ Female

Mailing Address | Apt # | City, State, Zip

Email Address | Primary Phone | ☐ Home ☐ Cell | Okay to call? Okay to text? ☐ Call ☐ Text

Occupation / Employer (or parent/guardian employer if patient is a minor) | Work Phone

Primary Care Provider Name (where you go for routine medical care) | City/State | Phone Number

Preferred Language

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Partner

Contact Preference ☐ Home ☐ Mobile ☐ Email ☐ Portal ☐ Mail

Emergency Contact

Contact Name | Phone Number | Relationship to Patient

~~Pharmacy Information~~

Name | Address | Phone Number

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last) | Social Security # | Date of Birth

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name | Policy Number/Member ID | Group Number

Policy Holder | Date of Birth | Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

Phone Number

Secondary Medical Insurance (if applicable)

SECONDARY Insurance Company Name | Policy Number/Member ID | Group Number

Policy Holder | Date of Birth | Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

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FINANCIAL AGREEMENT

I hereby instruct and direct my health insurance company, personal injury protection insurance company, and/or my attorney to pay by check, made out and mailed to Regency Pain & Therapy Institute, for healthcare services allowed and otherwise payable to me, under my current insurance policy, as payment toward the total charges for the professional services rendered by this office.

I agree that I am financially responsible for all charges incurred at this office; including any insurance deductible, co-pays, or services not covered by my insurance company, workers compensation, and/or my attorney.

I hereby acknowledge and agree to the following:

- A $35.00 fee will be assessed for returned checks.
- If copies of your medical records are needed, the first copy will be free of charge. For any additional copies required, there is a $6.50 fee per copy.
- We require a 48-hour notification should you be unable to keep your scheduled appointment for any type of office visit or procedure. Failure to do so could result in a no-show fee of $75.
- As a courtesy, we will call, email or text to remind you of your appointment one day in advance. However, you are still responsible for the appointment, even if we are unable to contact you. We understand that unforeseen events can occur such as illness or emergencies, but kindly give us a call if you're unable to keep your appointment time.
- Payment is required prior to or at time of service.
- Failure to pay could result in cancellation of appointment until payment can be rendered.

Signature _____ Date _____

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Authorization of Release of Protected Health Information to Family Members

I authorize Regency Pain & Therapy Institute to release protected health information to my family member(s) listed below:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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MEDICAL HISTORY FORM

Name _____ DOB _____ Age _____ ☐ Male ☐ Female

Medications Currently Taking (Please include all prescription, over-the-counter, vitamins, and supplements)

NAME OF MEDICATION	DOSAGE OF MEDICATION

Allergies to any medications, x-ray dyes or other substance? ☐ Yes ☐ No
(If yes, please list name of medication and any type of reaction)

_____

_____

Surgeries

DATE	DETAILS

Hospitalizations

DATE	DETAILS

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PAST MEDICAL HISTORY

PATIENT HISTORY (No Past Conditions ☐)

(Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.)

AUTOIMMUNE:
- ☐ Yes ☐ No Lupus
- ☐ Yes ☐ No Sjogren's
- ☐ Yes ☐ No Rheumatoid
- ☐ Yes ☐ No Celiac

BLOOD DISORDER:
- ☐ Yes ☐ No Blood Clots
- ☐ Yes ☐ No Bleeding Disorders
- ☐ Yes ☐ No Blood Transfusions
- ☐ Yes ☐ No Sickle Cell Disease
- ☐ Yes ☐ No Anemia

CANCER (TYPE):
- ☐ Yes ☐ No Skin
- ☐ Yes ☐ No Blood
- ☐ Yes ☐ No Thyroid
- ☐ Yes ☐ No Bone
- ☐ Yes ☐ No Lung
- ☐ Yes ☐ No Prostrate
- ☐ Yes ☐ No Breast
- ☐ Yes ☐ No Ovarian
- ☐ Yes ☐ No Kidney
- ☐ Yes ☐ No Colon
- ☐ Yes ☐ No Cervical
- ☐ Yes ☐ No Uterine
- ☐ Yes ☐ No Rectal

ENDOCRINE:
- ☐ Yes ☐ No Hyperthyroid
- ☐ Yes ☐ No Hypothyroid
- ☐ Yes ☐ No Low Testosterone
- ☐ Yes ☐ No Diabetes

GI:
- ☐ Yes ☐ No Acid Reflux
- ☐ Yes ☐ No IBS
- ☐ Yes ☐ No Pancreatitis
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Ulcers
- ☐ Yes ☐ No Constipation

HEART / CARDIAC:
- ☐ Yes ☐ No Abnormal EKG
- ☐ Yes ☐ No Heart Disease
- ☐ Yes ☐ No Heart Attack
- ☐ Yes ☐ No CHF
- ☐ Yes ☐ No High Cholesterol
- ☐ Yes ☐ No High Blood Pressure

INFECTIOUS:
- ☐ Yes ☐ No Cellulitis
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No Lyme
- ☐ Yes ☐ No HIV/AIDS
- ☐ Yes ☐ No STD
- ☐ Yes ☐ No Meningitis

PSYCHIATRIC:
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Bipolar
- ☐ Yes ☐ No Alcoholism
- ☐ Yes ☐ No Panic Attacks
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Drug Abuse
- ☐ Yes ☐ No Suicide Attempt

LUNG / PULMONARY:
- ☐ Yes ☐ No Allergies
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No COPD
- ☐ Yes ☐ No Home Oxygen

MUSCULOSKELETAL:
- ☐ Yes ☐ No Gout
- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Muscle Disease
- ☐ Yes ☐ No Osteoporosis

NEUROLOGIC:
- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Multiple Sclerosis
- ☐ Yes ☐ No Migraines
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Concussion

SKIN:
- ☐ Yes ☐ No Eczema
- ☐ Yes ☐ No Shingles
- ☐ Yes ☐ No Psoriasis
- ☐ Yes ☐ No Keloid
- ☐ Yes ☐ No Herpes
- ☐ Yes ☐ No Contusion

UROLOGICAL:
- ☐ Yes ☐ No Infections
- ☐ Yes ☐ No Kidney Stones
- ☐ Yes ☐ No Dialysis
- ☐ Yes ☐ No Kidney Disease

OTHER CONDITIONS NOT LISTED (Please provide us with any past disorders or diseases outside of those listed above)

_____

_____

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FAMILY HISTORY (MARK ALL THAT APPLY)

Condition	Father	Mother	Sibling	Condition	Father	Mother	Sibling
Heart disease				Thyroid disease			
Hypertension				Arthritis			
High cholesterol				Osteoporosis			
Heart attack				Depression/Anxiety			
Diabetes				Suicide			
Bleeding/clotting disorder				Drug/alcohol addiction			
Anemia				Infectious disease			
Asthma				HIV/AIDS			
COPD				Skin Disease			
Colon/Bowel problems				Cancer			
Kidney disease				Other			

Social History

Do you smoke or use other tobacco products? ☐ Yes ☐ No If yes, how much?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____
Do you use illegal or recreational drugs? ☐ Yes ☐ No Ifyes, how much? _____

Current Symptoms (Please describe any current body symptoms or pains with regard to the following areas)

Head / Face _____
Neck _____
Shoulders _____
Arms _____
Chest _____
Abdomen _____

Low back _____
Pelvis _____
Hips _____
Legs _____
Knees _____
Feet _____

Please provide any other details you would like to add: _____

_____

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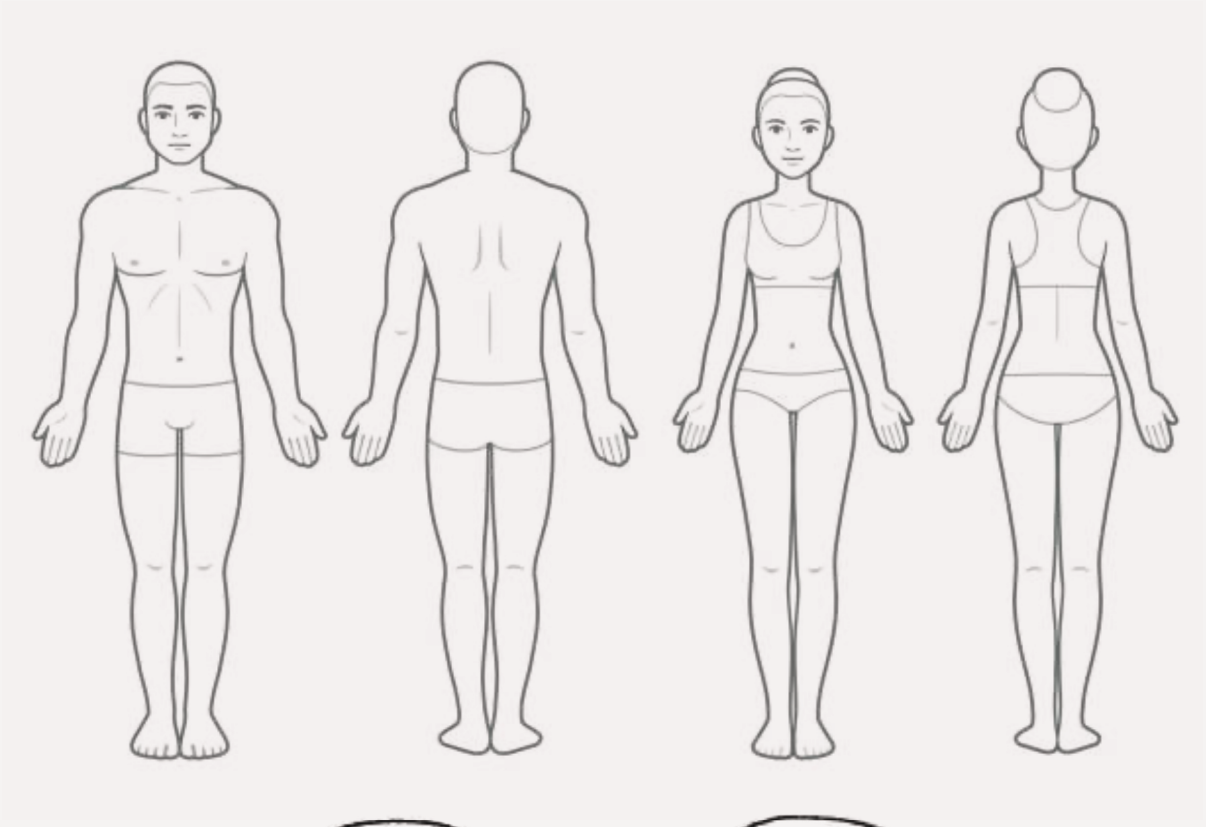
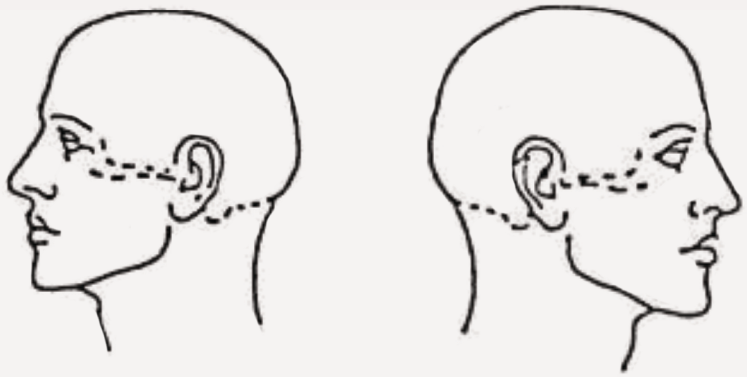
CURRENT SYMPTOMS & PAIN

Using the symbols below, mark the area on your body where you feel the described sensation.

ΔΔΔΔ	= = = =	OOOO	XXXX	///////	.....
Aching	Numbness	Pins & Needles	Burning	Stabbing	Other





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SOAPP®-R QUESTIONNAIRE

The following are some questions given to 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.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

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SOAPP®-R QUESTIONNAIRE (CONTINUED)

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Pain Management Informed Consent

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug (medication) therapy to be used, so that you may make an informed decision whether or not to take the drug(s) knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your physician's expectations that are necessary for patient compliance. For the purpose of this agreement the use of the word "physician" is defined to include not only your physician but also your physician's authorized associates, physician assistants, nurse practitioners, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition of chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with my Pain Medicine Physician the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief, improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that accidental overdose, injury and death are also possibilities as a result of taking these medication(s).

I understand that concurrently consuming sedating substances like alcohol, or taking additional types of sedating controlled medications, such as benzodiazepines, along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical specialists to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy.

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INFORMED CONSENT FORM (CONTINUED)

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND UNDERSTAND THAT I WILL UNDERGO MEDICAL TESTS AND EXAMINATIONS BEFORE AND DURING MY TREATMENT. Those tests include random unannounced checks for drugs (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from my Pain Medicine Physician's care.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment may require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

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INFORMED CONSENT FORM (CONTINUED)

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

FOR FEMALE PATIENTS ONLY:

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

_____ If I am not pregnant, I will take appropriate precautions to avoid pregnancy during my course of treatment. I accept that it is **my responsibility** to inform my physician immediately if I become pregnant.

_____ **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**.

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo, fetus, or baby.

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PAIN MANAGEMENT AGREEMENT

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are many strict federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

The term "Pain Medicine Physician" below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

My Pain Medicine Physician may at any time choose to discontinue medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior.

(*Patient Shall Acknowledge All Provisions by Initialing*)

► _____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.

► _____ I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and controlled substances for the treatment of chronic pain.

► _____ I agree to submit to laboratory tests for drug levels upon request, including urine and/or blood screens, to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for alcohol or illegal substance(s), treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary, such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

► _____ Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling, and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. My Pain Medicine Physician may limit the number and frequency of prescription refills.

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PAIN MANAGEMENT AGREEMENT (CONTINUED)

- _____ I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may not be replaced. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation may, at his/her sole discretion, issue an early refill.**

- _____ My Pain Medicine Physician will manage all of my chronic pain symptoms**. Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatment of chronic pain**. I will receive controlled substance medication(s) **only from ONE Pain Medicine Physician,** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician and my other specialists.

- _____I agree that I **will inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.

- _____I hereby give my Pain Medicine Physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my Pain Medicine Physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

- _____ I will use the medication(s) **exactly as directed by my Pain Medicine Physician**. **Any unauthorized increase** in the dose of medication(s) may cause the discontinuation of my pain treatment(s).

- _____ If anyone other than my Pain Medicine Physician prescribes me medication(s) to treat acute, post-surgical or chronic pain, then I will **disclose** this information to my Pain Medicine Physician at or before my next date of service, which must include, at a minimum, the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

- ____I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which are designed to reverse the effects of an accidental or intentional overdose of pain medication.

- _____All medication(s) must be obtained at **one pharmacy designated by me**, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my Pain Medicine Physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my Pain Medicine Physician to release my medical records to my pharmacist as needed.

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PAIN MANAGEMENT AGREEMENT (CONTINUED)

- _____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued**.

- _____ I must **keep all follow-up appointments** as recommended by my Pain Medicine Physician or my treatment may be discontinued.

- _____ I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to my medications.

- _____ I will **not use any cannabidiol (CBD) products unless one of my physicians has prescribed me Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the use of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.**

- _____ I agree to be seen in **in-person office visits** because in Texas it is illegal to use Telehealth for the treatment of chronic pain with controlled substances.

- _____If it appears to my Pain Medicine Physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my Pain Medicine Physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my Pain Medicine Physician liable for problems caused by the discontinuance of medication(s).

- _____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain medicine program** recommended by my Pain Medicine Physician to achieve increased function and improved quality of life.

- _____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and I will discontinue it before starting these medications.

REGENCY
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I CERTIFY AND AGREE TO THE FOLLOWING:

I. _____ I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

II. _____ I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).

III. _____ **No guarantee or assurance has been made** to me as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

IV. _____ I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

V. _____ If I become a patient in this clinic and receive controlled substances to control my pain, this Pain Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

_____ _____

Patient Signature | Patient Printed Name

_____ _____

Physician Signature *(or Appropriately Authorized Assistant)* | Physician Printed Name *(or Appropriately Authorized Assistant)*

Name and Contact Information for Pharmacy

Name: _____

Pharmacy Location: _____ Phone: _____