WELLCOME TO MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, MD

_____
Today's date

PATIENT INFORMATION

Name : _____
Last **First** **Middle Initial**

Address : _____
City, State, Zip Code

Home phone: _____ **Cell phone:** _____ **SS Number** _____ - _____-_____

Email : _____@_____.com **Sex:** ____F ___M **Date of Birth:** _____-_____- _____

_____**Minor** _____**Single** _____**Married** _____**Divorced** _____**Widowed** **Language:**_____

Ethnicity: ____ **Caucasian** _____**African-American** _____**Latino** _____**Other** _____

Whom should we thank for referring you? _____

Emergency contact: _____ **Phone:** _____**Occupation:**_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____

Company Address: _____**Phone:**_____

Insured's Name: _____**DOB:**_____

Policy No:_____ **Group No.** _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Company Address : _____**Phone:**_____

Insured's Name: _____**DOB:**_____

Policy No.:_____ **Group No.** _____

I hereby authorize payment directly to Bayoan Martinez-Cruz, M.D. of all insurance benefits, otherwise payable to me for Service rendered. I understand that I am financially responsible for all charges and services rendered, whether or not paid by insurance, on behalf of myself and my dependents. I authorize the above doctor/provider/supplier or services in this office to release any information required to secure the payment of benefits.

_____ _____
Signature of Responsible Party **Today's date**

MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, MD

Name: _____ _____ ____ _____
Last First M.I. Date of Birth

MEDICAL HISTORY

Purpose of your visit today: _____

Past illnesses, including dates:

_____

_____

Surgeries, including dates: _____

_____

_____

Allergies to medications? Please list, including reaction(s): _____

_____

Current medications, including dosages and frequency: _____

_____

_____

Immunizations, including dates:

Influenza: _____ Pneumonia _____ Shingles _____

SOCIAL HISTORY

Marital Status: ____Married ____ Single ____ Divorced ____Widowed Children ages _____

Smoker: ____Yes ____No If stopped, when, and how long did you smoke? _____

Alcohol use: ____No ____Occasional ____Frequent Exercise: ____Never ____Occasional ____Frequent

FAMILY HISTORY

	Living/Deceased	If deceased, date and cause of death
Father	_____	_____
Mother	_____	_____
Sibling(s)	_____	_____
	_____	_____
Children:	_____	_____

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

Name: _____ _____ ___ _____
Last First M.I. Date of Birth

REVIEW OF SYMPTOMS THAT YOU FREQUENTLY HAVE

GENERAL	EYES	EARS
• Weakness • Fatigue • Fever • Night sweats • Dizziness • Headaches • Weight loss • Weight gain • Others _____ • None	• Contact lenses • Cataracts • Blurred vision • Glaucoma • Double vision • Pain • Others _____ • None	• Hard of hearing • Deafness • Ringing • Ear ache • Dizziness • Wax • Others _____ • None
NOSE	**MOUTH/THROAT**	**BREASTS**
• Nose bleeds • Pain • Nasal drip • Runny nose • Sinus congestion • Polyps • Others _____ • None	• Bleeding • Ulcers • Sore throat • Hoarseness • Difficulty to swallowing • White spots • Loss of taste • Gum problems • Others _____ • None	• Discharge • Nodules/lumps • Skin changes • Tenderness • Others _____ • None
LUNGS	**HEART**	**GASTROINTESTINAL**
• Cough • Shortness of breath • Wheezing • Asthma • Chest pain • Congestion • Blood • Phlegm • Others _____ • None	• Palpitations • Chest pressure • Rapid heart beat • Blood clots • Murmur • Swollen legs • Others _____ • None	• Abdominal pain • Nausea/vomiting • Indigestion • Constipation • Blood in stool • Irregular bowels • Food intolerance • Heartburn • Others _____ • None
GENITOURINARY	**GYNECOLOGICAL**	**MUSCULOSKELETAL**
• Urgency • Incontinence • Flank pain • Kidney stones • Frequent urination at night • Blood in urine • Bed wetting • Burning while urinating • Others _____ • None	• Post menopausal • Vaginal discharge • Hot flashes • Painful intercourse • Menstrual cramps • Loss of libido • Others _____ • None	• Pain • Cramps • Joint pain/stiffness • Back pain • Joint swelling • Injuries • Weakness • Others _____ • None
NEUROLOGICAL	**PSYCHIATRIC**	**ENDOCRINE**
• Seizures • Hand trembling • Slurred speech • Shuffling gait • Tingling/numbness • Paralysis • Weak grip • Loss of sensation • Others _____ • None	• Depression • Poor sleep • Anxiety • Panic attacks • Mania • Obsessiveness • Suicidal thoughts • Others _____ • None	• Diabetes • Hypoglycemia • Heat/cold intolerance • Loss of hair • Erectile dysfunction • Others _____ • None

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL RECORDS

RELEASE: Requesting information from another Provider/Practice to us

Patient's Name: _____

Date of Birth: _____ Phone: _____

Requesting from: _____ Fax: _____

I authorize the release of the following of my protected health information:

___ ALL RECORDS ___ Office Notes ___ Radiology Reports

___ Pathology Reports ___ Laboratory Reports ___ EKG Results

___ Last Office Notes ___ Other _____

To : Martinez Cruz Medical Associates, LLC
781 Hwy 466, Lady Lake, Florida 32159
Phone : (352) 750-6650
Fax : (352) 750-6653

The purpose of this authorization is for:

___ Medical Treatment

___ Other (specify): _____

_____ _____ _____

Patient Signature Print Name Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative signing on behalf of the patient, please complete the following:

_____ _____ _____

Signature Print Name Date

_____

Relationship to Patient

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Martinez-Cruz Medical Associates of The Villages, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Bayoan Martinez-Cruz, M.D.'s *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

With my consent, Martinez-Cruz Medical Associates of The Villages, LLC may call designated locations and leave messages on voicemail or in person regarding any items that assist the practice of carrying out TPO, such as appointment reminders, insurance issues, and any call pertaining to my clinical care, including laboratory results, among others. Also, with my consent, Bayoan Martinez-Cruz, M.D. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements

By signing this form, I am giving my consent to Martinez-Cruz Medical Associates of The Villages, LLC for use and/or disclosure of my PHI to carry out TPO. If I do not sign this consent, the practice may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance on my prior consent.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand that Martinez-Cruz Medical Associates of The Villages, LLC is authorized by me to use or disclose my PHI for treatment, payment, or other health care operations. I specifically authorize any current employee or owner of Martinez-Cruz Medical Associates of The Villages, LLC, or any other individual listed below, to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used/ disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so in writing, at any time.

Description of the information to be used/disclosed (check all that apply):

( ) The patient's entire health record

( ) Other: _____

Name(s) of person(s) that my PHI may be disclosed to, and my relationship to them (spouse, other family members, friends):

_____

_____

_____

I understand that I have the right to revoke this authorization at any time. In order for the revocation to be effective, Martinez-Cruz Medical Associates of The Villages, LLC must receive the revocation in writing. I also understand that by signing below, I am giving Martinez-Cruz Medical Associates of The Villages, LLC consent for my treatment, and that I agree to all the terms listed above.

Patient's signature: _____ Date: _____

Print patient's name: _____

Legal guardian's signature: _____

Print legal guardian's name: _____

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

Dear Patient:

Florida statutes require that we provide our patients with information concerning their rights to a Living Will and/or Advanced Directive.

An **ADVANCED DIRECTIVE** is a witnessed statement made by a competent member regarding his/her wishes or desires in regard to future health care (for example, provide artificial life support).

A **LIVING WILL** is a formalized version of an **ADVANCED DIRECTIVE.**

Please take this information home and carefully review it. If you wish to execute an Advanced Directive or Living Will, please notify this office on your next visit.

I have received a copy of Health Care Directives and understand my rights relating to Advanced Directive and Living Will.

PLEASE CHECK ONE:

_____ **I do not have a Living Will.**

_____ **I do have a Living Will and will provide a copy to this office.**

Florida law requires that your health provider or healthcare facility recognize your rights while you are receiving medical care, and that you respect the healthcare providers or healthcare facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility.

Patient's signature: _____

Printed name: _____

Witness: _____ Date: _____

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice took effect on April 14, 2003 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes, and we will make the new Notice available on request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

TREATMENT: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

DISCLOSURE: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you *choose* to involve in your care, only if you agree that we may do so.

PAYMENT: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

EMERGENCIES: We may use or disclose your health information to notify, or assist in the notification of, a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up fill prescriptions, x-rays or other similar forms of health information, and/or supplies, unless you have advised us otherwise.

HEALTHCARE OPERATIONS: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery requests or other lawful processes. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

PUBLIC HEALTH RESPONSIBILITIES: We will disclose your healthcare information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and prevent and control disease, injury, and/or disability.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing purposes unless we have your written authorization to do so.

NATIONAL SECURITY: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voice mail messages, postcards, or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

ACCESS: On written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or an explanation of our fee structure.

AMENDMENT: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

NON-ROUTINE DISCLOSURE: You have the right to receive a list of non-routine disclosures we have made of your healthcare information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we don ot keep a record of routine disclosures; therefore, these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment, or healthcare operations.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree with these additional restrictions, but if we do, we will abide by our agreement (except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your healthcare information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS:

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel that we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing, to the Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:

Practice Name: Martinez-Cruz Medical Associates of The Villages, LLC
Privacy Officer: Bayoan Martinez-Cruz, M.D.
Address: 11950 CR-101, Suite 206, The Villages FL 32162
Telephone: (352) 750-6650
Fax: (352) 750-6653

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received the Martinez-Cruz Medical Associates of The Villages, LLC HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION: I, the below named patient, do hereby any physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g., Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug-related condition, and records concerning diagnosis and treatment when requested by such third parties for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIIXIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify that all insurance pertaining to treatment shall be assigned to the physician treating me.

PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE: This assignment will remain in effect until revoked by me in writing.

CONSENT FOR TREATMENT: I, the below named patient, hereby give my consent for treatment to all physicians associated with Martinez-Cruz Medical Associates of The Villages, LLC.

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Martinez-Cruz Medical Associates of The Villages, LLC to discuss my medical condition with, or release my medical records to the below named person(s):

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NO SHOWS/LAST MINUTE CANCELLATIONS/LAST MINUTE RESCHEDULES: Providers and staff of Martinez-Cruz Medical Associates of The Villages, LLC rely on the prescheduled appointments to plan their day-to-day activities. Last minute reschedules or cancellations and no-shows disrupt the daily activities and also curtail the ability to schedule another member/ patient in your prescheduled slot. If you have to cancel or reschedule your appointment, please provide us with at least 48 hours of prior notice. If you reschedule, cancel, or are a no-show to your prescheduled appointment, we may charge a $25.00 fee directly to you. Please note that this charge will not be billed to any third party (including your insurance) but directly to you, and you will be responsible for payment of this charge prior to any further encounters.

COLLECTION AGENCY: In the event your account becomes delinquent and is turned over to a collection agency and/or attorney, you will be financially responsible for all associated collection fees and legal fees that Martinez-Cruz Medical Associates of The Villages, LLC incurs through the process utilized to collect the delinquent balance. Please be aware that if your account is turned over to a collection agency, you can be discharged from the practice. _____

RETURNED CHECKS: Checks returned to Martinez-Cruz Medical Associates of The Villages, LLC by its bank will be assessed a returned check fee, in addition to the original amount of the check. You will have ten (10) days to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time, the check will be sent to the State Attorney's Office for further collection. _____

Please remember that insurance is considered a method of reimbursing the patient foe fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, while others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, and/or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed sixty (60) days.

DATE: _____ PATIENT'S SIGNATURE: _____

SUBSCRIBER'S SIGNATURE (if different from patient): _____

MARTINEZ-CRUZ
MEDICAL ASSOCIATES

Martinez Cruz Medical Associates of The Villages
781 Hwy 466, Lady Lake, Florida 32159

NAME:_____ DATE:_____

CAGE-AID:

Do you smoke, drink alcohol, or use any recreational or non-prescription drug? **Yes** _____ **No**_____

If YES, which ones, and how much do you normally use or have in a week's time?_____

_____

Have you ever felt that you should cut down on your drinking, smoking, or drug use? **Yes**_____ **No**_____

Have people annoyed you by criticizing your drinking, smoking or recreational drug use **Yes**_____ **No**_____

Have you ever felt bad or guilty about your drinking, smoking or recreational drug use? **Yes** _____ **No**_____

Have you ever had a smoke, drink or some other kind of recreational drug or pain-killer in the morning, to steady your nerves or get rid of a hangover? **Yes** _____ **No**_____

Thank you very much!

*We are looking forward to working together with you to help you feel much better!

MARTINEZ-CRUZ
MEDICAL ASSOCIATES

Name _____ **Date**_____

PATIENT HEALTH QUESTIONNAIRE

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

		1	2	3	4
	Questions	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
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/staying asleep, 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 fidgety/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 in some way.	0	1	2	3

1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	*Worrying too much about different things*	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid if something awful might happen	0	1	2	3
8	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**
		0	1	2	3

MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC

CONTROLLED SUBSTANCE AGREEMENT

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both, you and the physician by establishing guidelines within the laws, for proper and controlled substance use. The words "we and our" refer to the facility and the words "I" "you" "me" or "my" refer to you, the patient.

1.- All controlled substances must come from the physician whose signature appears bellow or, during his/her absence, by the covering physician, unless specific authorizations is obtained for an exception. I understand that I must tell the physician whose signature appears bellow or, during his/her absence the covering physician, all drugs that I am taking, have purchased, or have obtained, even over- the- counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed)

2.- All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ Phone ( ) _____

3.- You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.

4.- Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.

5.- I will not consume the excessive amount of alcohol in conjunction with controlled substances. I will not use, purchase or otherwise obtain other legal drugs except as specially authorized by the physician whose signature appears bellow or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g. alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.

6.- Medication or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on the airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7.- Early refills will not be given. Renewals are based upon keeping schedule appointments. Please do not phone for prescription after hours or on weekends.

8.- In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refill on controlled substances will not be given.

9.- I understand that failure or adhere to these policies may result in cessation of therapy with controlled substances prescribing by this physician and other physicians at the facility and that law enforcement officials may be contacted.

10.- I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this copy has been given to me.

_____

PATIENT'S FULL NAME

_____ DATE : _____

PATIENT'S SIGNATURE

_____ DATE : _____

PHYSICIAN SIGNATURE