

HANLEY PAIN & REHABILITATION CENTER, INC.

Allison W. Hanley, M.D.

Board Certified American Board of Internal Medicine
Diplomate American Academy of Pain Management
Certified Medical Review Officer

**PAIN MANAGEMENT REGISTRATION
(PLEASE PRINT)**

Today's Date: _____ Who can we thank for referring you? _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Last Name First Name Middle Initial

Social Security #: _____ Driver's License #: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work: _____ Cellular: _____

Is today's visit work related? Yes No Auto Accident? Yes No Date of Accident: _____

EMERGENCY CONTACT

Full Name: _____ Relationship to Patient: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Phone: _____

REFERRING PHYSICIAN

Physician Name: _____ Physician Specialty: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Office Phone #: _____ Office Fax #: _____

CONSENT FOR TREATMENT:

The undersigned hereby consent to the provision of examination, treatments, medical laboratory procedures, drugs, and supplies to the patient as ordered or requested by the patients' physician and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures or examinations.

Patient Signature: _____ Date: _____
(PHOTOCOPY AS VALID AS ORIGINAL)

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NOTICE TO PAIN MANAGEMENT PATIENTS:

PAYMENTS & APPOINTMENTS:

_____ Our pain management service is separate from our Internal Medicine practice. Therefore, we are
Initial not contracted with any group health insurances. All pain management services are on a self-pay basis and have the following fees:

- Initial Office Visit: \$450.00
- Follow-up Visits: \$125.00
- Random Drug Screens: By Urine (In house) \$25.00
- By Urine (Sent to Lab) \$180.00 - \$265.00
- Other Necessary Labs: Prices will be given at time of lab draw

_____ All payments are due in full at time of service. If you are not able to make your payment, your
Initial appointment will be rescheduled to a time that will be more financially suitable for you. (All appointments are based on availability)

_____ Appointments will be required every 2 (two) weeks for the first 2 (two) months to monitor
Initial compliance. A re-evaluation will be done after this period.

_____ All appointments require 24 hour cancellation notice; otherwise a charge of \$5.00 will be assessed.
Initial All no shows will be charged \$10.00.

_____ We will only be able to provide you with pain management services. If you need to establish with
Initial a primary care physician, we will gladly refer you to one.

MEDICATIONS:

_____ Medications/prescriptions can only be given in an office visit. No prescription refills will be done
Initial over the phone or called into a pharmacy.

_____ All medications/prescriptions are to be taken as the doctor has instructed and may not be altered
Initial without the consent of the doctor during an office visit.

_____ You must inform the doctor if you obtain medications/prescriptions from another doctor
Initial or other source.

_____ Any medication/prescription given to you is your responsibility and must be kept in a safe, secure
Initial place. No lost medication/prescription will be replaced regardless of why it was lost.

_____ Random drug screenings will be performed to keep your treatment as safe as possible. If drug
Initial screen is denied by you, medications/prescriptions will not be prescribed.

_____ ****Failure to follow office policies and guidelines will result in termination of care for non-
Initial compliance

_____ Patient Name

_____ Birth Date

_____ Patient Signature

_____ Date

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MEDICATION MANAGEMENT AGREEMENT

This Agreement between _____, (“Patient”) and Hanley Pain and Rehabilitation Center, Inc., (“Doctor”) is for the purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a Doctor/Patient relationship.

_____The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

_____I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

_____I realize that all of the medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

_____I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

_____I will not use any illegal controlled substances, including marijuana, cocaine, etc.

_____I will not share, sell, or trade my medication for money, goods or services.

_____I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor. I understand it is against the law to do so. If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure there is no duplication.

_____I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

_____I agree to use _____ Pharmacy, located at _____, telephone number _____, for all my pain medication. If I change pharmacy for any reason, I agree to notify the Doctor at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy’s address and telephone number.

_____I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Florida Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this Agreement to my pharmacy.

_____I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with my regimen of pain control medication.

_____I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

_____I understand that this medication regimen will be continued for a period of four months. My case will be reviewed at the end of that period. If there’s no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

Doctor and Patient agree that this Agreement is essential to the Doctor’s ability to treat the Patient’s pain effectively and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This Agreement is entered into on this _____ day of _____, 20 _____

Patient Printed Name

Date of Birth

Patient Signature

Doctor Signature

Witness Signature

I acknowledge receipt of a copy of this Agreement on the date stated above. _____
Patient Signature