NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any tim at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Patient D.O.B._____

Patient Signature: _____ Date: _____

I give permission for Mercer Bucks Medical Associates and its employees to speak with the following on my behalf:

Name:_____ Relationship: _____

Name:_____Relationship:_____

OFFICE USE ONLY

We attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Name:_____ **Initials:**_____ **Reason:**_____

MERCER BUCKS MEDICAL ASSOCIATES
1411 WOODBOURNE ROAD
LEVITTOWN, PA 19057
PHONE: 215-943-2000
FAX: 215-943-4439

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

PATIENT INFORMATION (PLEASE PRINT)

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

RELEASE MY MEDICAL RECORDS FROM:

DR/PRACTICE NAME: _____

TELEPHONE: _____

FAX: _____

TO:

MERCER BUCKS MEDICAL ASSOCIATES
1411 WOODBOURNE ROAD
LEVITTOWN, PA 19057

PHONE: 215-943-2000
FAX: 215-943-4439

Please release a copy of my medical records, including but not limited to progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS

PATIENT: _____ DATE: _____

MERCER BUCKS MEDICAL ASSOCIATES

AGREEMENT ON CONTROLLED SUBSTANCES THERAPY FOR CHRONIC PAIN TREATMENT

ıe purpose of this agreement is to create an understanding regarding **controlled substances (a type of medication that is ɛgulated by states and the Federal Government)** that may benefit your chronic pain symptoms. My goal is to treat you safely ith these potent medications and also to prevent abuse of or addiction to these medications. Medications such as opioids ıarcotic analgesics), benzodiazepine tranquilizers, barbiturate sedatives, and muscle relaxants such as Soma (carisoprodol), ıat may be useful in managing pain, can be problematic in several ways. These medications have "street value" and potential r abuse. Although these medications may be prescribed with goal of improving your comfort and functionality, their medical ;e is also associated with risk of serious adverse effects such as development of an addiction disorder or a relapse in a person ith a prior addiction history. The extent of this risk is uncertain, but it is known to be higher in certain vulnerable patients. y goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your pain and ıproving your function, and when possible, have it tapered and eventually discontinued, while at the same time monitoring ıd managing these potential risks.

ːcause these medications have the potential for abuse of diversion (i.e. sharing, trading or selling to ANYONE other than ıose name is on the prescription), strict accountability is necessary for both medical safety and legal reasons. Therefore, ɛ following policies are agreed to by you, the patient, to help me keep you safe and to provide you with good care.

You must get a prescription for all controlled substances from the physician whose name appears at the end of this agreement or, during his/her absence, by the covering physician, unless specific written authorization is obtained for an exception. (Multiple sources can lead to untoward medication interactions or poor coordination of treatment.)
You must obtain all controlled substances from the same pharmacy. Should the need arise to change your pharmacy you must notify this office. The pharmacy that you have selected to use is:

Name & Address_____**Phone**_____

You must inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.
You must give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability and coordinating your care.
YOU MAY NOT SHARE, SELL OR OTHERWISE PERMIT OTHERS TO HAVE ACCESS TO YOUR MEDICATIONS. YOU MUST TAKE ALL MEDICATIONS EXACTLY HOW THEY ARE PRESCRIBED, UNLESS YOU DEVELOP SIDE EFFECTS. IF YOU DEVELOP SIDE EFFECTS, YOU MUST CONSULT WITH YOUR DOCTOR OR LOCAL EMERGENCY PROVIDERS.
You must not stop these medications abruptly or without consulting the prescribing physician, and an abstinence/withdrawal syndrome may develop.
YOU MUST AGREE THAT YOUR URINE MAY BE TESTED FOR CONTROLLED SUBSTANCE BEFORE INITIATION OF THERAPY AND THAT RANDOM URINE FOLLOW UP TESTING WILL BE DONE. YOU MUST COOPERATE IN SUCH TESTING, AND YOU MUST AGREE THAT THE PRESENCE OF UNAUTHORIZED SUBSTANCES, ILLICIT SUBSTANCE OR ABSENCE OF PRESCRIBED MEDICATIONS MAY PROMPT REFERRAL FOR ASSESSMENT FOR ADDICTIVE DISORDER AND POSSIBLE TAPERING AND DISCONTINUATION OF THE CONTROLLED SUBSTANCES IMMEDIATELY OR IN THE FUTURE.
IF FOR ANY REASON YOUR URINE TEST DOES NOT COINCIDE WITH THE MEDICATION THAT IS PRESCRIBED TO MORE THAN (3) THREE TIMES YOU WILL BE ASKED TO FIND ANOTHER PHYSICIAN TO TAKE CARE OF YOUR MEDICAL NEEDS.
You will not give your prescriptions or bottles of these medications to anyone else. These substances may be sought by individuals with chemical dependency and should be closely safeguarded. You will take the highest degree of care with your medications and prescriptions. You will not leave them where others might see or otherwise have access to them.
YOU MUST BRING ORIGINAL CONTAINERS OF MEDICATION TO EACH OFFICE VISIT.

11. You must keep all controlled substances in a secure area. These medications may be HAZARDOUS or LETHAL to a person who is not tolerant to their effects, especially for a child, you must keep them out of reach of such people.
12. You must exercise extreme caution when taking these medications while driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery. The effects of these medications are particularly problematic during any dose changes. If you are the slightest bit impaired, you must refrain from these activities.
13. You must discuss the long-term use of controlled substances with your physician. Prolonged opioid use can be associated with serious health risks. You need to understand these risks
14. You must agree that medications will not be replaced if they are lost, flushed down the toilet, destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft and present that report to the prescribing physician, an exception **MAY** be made at the discretion of your treating physician.
15. **NO EARLY REFILLS WILL BE GIVEN.**
16. You understand that prescriptions may be issued early only if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacists that they are not to be filled prior to due date.
17. **YOU AGREE THAT, IF THE RESPONSIBLE LEGAL AUTHORITIES HAVE QUESTIONS CONCERNING YOUR TREATMENT, AS MIGHT OCCUR, FOR EXAMPLE, IF YOU WERE OBTAINING MEDICATIONS FROM SEVERAL PHARMACIES, ALL CONFIDENTIALITY IS WAIVED AND THESE AUTHORITIES WILL BE GIVEN FULL ACCESS TO OUR RECORDS OF CONTROLLED SUBSTANCES ADMINISTERED.**
18. You agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance prescribing by this physician and any associating physician. And a referral for further specialty assessment will be made.
19. You agree that prescription renewals are contingent on keeping scheduled appointments and results of urine testing. **Do not phone office for prescriptions after hours, weekends or holidays.**
20. **IF YOU RECEIVE A CONTROLLED SUBSTANCE PRESCRIPTION IN AN EMERGENCY ROOM FOR ANY REASON YOU MUST REPORT THAT TO YOUR PRESCRIBER, IN WRITING WITHIN 48 HOURS.**
21. You recognized that any medical treatment is a trial, and that continued prescription is contingent on evidence of benefit and improved functionality.
22. You acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to you and that you have had the opportunity to ask any questions that you may have.

You understand and agree that failure to adhere to these policies will be considered noncompliance and will result in cessation of opioid prescribing by your physician and dismissal from this medical practice.

You affirm that you have full right and power to sign and be bound by this agreement. You further affirm that you have been given the opportunity to ask any questions you may have and that you have read, understand, and accept all of its terms.

PATIENT NAME (PRINTED)_____ **DATE**_____

PATIENT SIGNATURE_____ **WITNESS**_____

COPY GIVEN BY_____

PHYSICIAN NAME_____

FIRST DOCS

First Name_____ Middle Initial_____

Last Name_____

Gender (Circle One) Male Female

Date of Birth_____ Social Security_____

Email Address_____

Home Phone:_____

Mobile Phone:_____ Is it OK to send appt. text to phone Y N

Work Phone:_____

Home Address:_____

City_____ State_____ Zip Code_____

Past Surgeries:_____

_____

Medical Problems:_____

_____

Social History: Alcohol Use Yes No Recreational Drugs Use Yes No

Tobacco Use Never Former Current

Allergies Medication_____

Food_____ Environmental_____

Family Medical History:

Great Grandparent_____

Grandparent_____

Parent_____

Sibling_____

Child_____

FIRST DOCS

MEDICATION LIST

Medication	Dose	Times Taken per Day