ORTHOPAEDIC ASSOCIATES
The Strength of Experience

Fort Walton Beach
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Destin, FL 32541

Niceville
554-D Twin
Cities Boulevard
Niceville, FL 32578

Panama City
1827 Harrison Avenue
Panama City, FL 32405

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536

Lumbar

Name: _____ Date:_____

Please read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem *right now***.

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights if they are conveniently positioned.
F. I can only lift very little weights, at the most.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. I have some pain with walking but it does not increase with distance.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than a half-mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than half an hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than half an hour without increasing pain.
E. I cannot stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from social life at all.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

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SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

LUMBAR index score: _____%

Patient Signature: _____

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Cervical

Name: _____ Date:_____

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem *right now***.

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned.
D. Pain prevents me from lifting heavy weights, but I can manage light it medium weights if they are conveniently positioned.
E. I cannot lift very heavy weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headache

A. I have no headaches at all.
B. I have slight headaches which come frequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty concentrating when I want to.
E. I have a great deal of difficulty concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1 – 2 hours sleepless).
D. My sleep is moderately disturbed (2 – 3 hours sleepless).
E. My sleep is greatly disturbed (3 – 5 hours sleepless).
F. My sleep is completed disturbed (5 – 7 hours sleepless).

SECTION 10 – Recreation

A. I am able to engage in all recreational activities with no pain in my neck at all.
B. I am able to engage in all recreational activities with some pain in my neck.
C. I am able to engage in most, but not all, recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

CERVICAL index score: _____%

Patient Signature: _____

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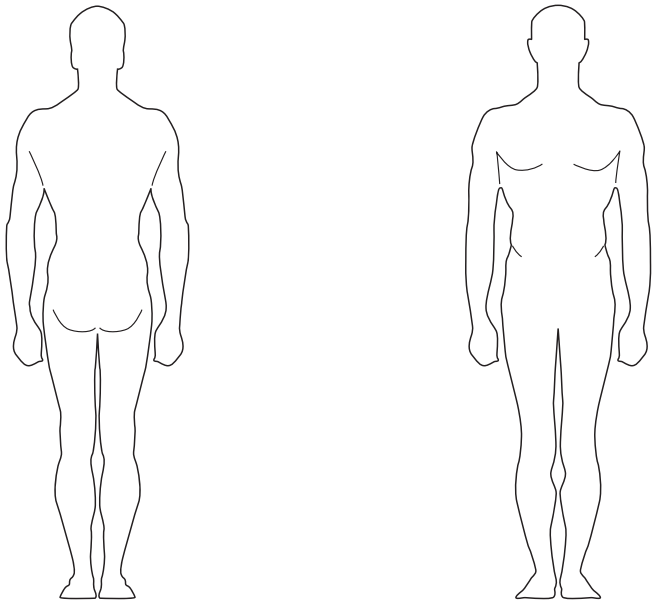
Patient Name: _____ Date: _____

Please mark an "X" on the body part(s) where you have pain.
Mark a "0" on the body parts where you have numbness.



Neck

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

Right Arm

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

Left Arm

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

Back

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

Right Leg

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

Left Leg

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

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Patient's Name:_____ Date: _____

This form must be filled out at each office visit.
We are required to have documentation of medications and allergies for each visit; because of this we are unable to accept "no change" or "same as before" answers of this form.

Medications currently taking	Dosage	Frequency

Allergies

_____
_____
_____
_____

Pharmacy Name: _____ Address: _____

Phone: _____

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Patient Questionnaire

Patient's Name:_____ Age: _____ Date: _____

JOB DESCRIPTION

Occupation: _____ Number of years at this job: _____
Are you currently working? ☐ YES ☐ NO
If so … ☐ Part-time ☐ Full-Time ☐ Regular Duty ☐ Modified Duty Working: _____ Hrs/Wk
What are your restrictions, if any? _____
Does your job require you to: (please check all that apply)
☐ Lift or carry greater than 15 lbs. ☐ Bend or twist repetitively.
☐ Work overhead. ☐ Repetitive motion of the arms or legs.

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date of problem/symptoms started: _____
Location of symptoms/pain when the problem started: _____

HOW DID THE PROBLEM START?

☐ Home/Leisure ☐ At Work ☐ Motor Vehicle Accident ☐ Fall ☐ Other: _____
Please briefly describe: _____
Location of symptoms/pain now: _____
Frequency of symptoms/pain: (please check one)
☐ CONSTANT ☐ INTERMITTENT ☐ RARE
Since the onset of symptoms, has the problem: (please check one)
☐ IMPROVED ☐ WORSENED ☐ STAYED THE SAME
Does coughing or sneezing cause any pain? ☐ YES ☐ NO
If so, where? _____
Do any of the following activities make your symptoms worse? (please check all that apply)
☐ WALKING ☐ LYING ☐ BENDING/TWISTING ☐ WORKING OVERHEAD ☐ SITTING
☐ KNEELING ☐ LIFTING/CARRYING ☐ STANDING ☐ TYPING ☐ PUSHING/PULLING
☐ OTHER: _____
List anything (i.e. activities, positions, or treatments) that makes the pain better: _____
_____
Do you have any weakness, if so, which arm, leg, or muscle? _____
Have you had any new or recurrent problems with:
Control of urination? ☐ YES ☐ NO
Bowel movements? ☐ YES ☐ NO
Have you experienced recent weight loss or fevers? ☐ YES ☐ NO

Patient Signature: _____

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HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

TEST	RECEIVED	DATE OF TEST/LOCATIONS
X-Ray	☐ YES ☐ NO	_____
MRI Scan	☐ YES ☐ NO	_____
CT Scan	☐ YES ☐ NO	_____
Bone Scan	☐ YES ☐ NO	_____
EMG	☐ YES ☐ NO	_____
Other:	☐ YES ☐ NO	_____

MEDICATIONS	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories	Naprosyn, Ibuprofen, Vioxx	☐ YES ☐ NO	☐ YES ☐ NO
Cox-2 Inhibitors	Voltaren, Celebrex, Bextra	☐ YES ☐ NO	☐ YES ☐ NO
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	☐ YES ☐ NO	☐ YES ☐ NO
Pain Medication	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	☐ YES ☐ NO	☐ YES ☐ NO
Oral Steroid	Prednisone, Medrol Dosepak	☐ YES ☐ NO	☐ YES ☐ NO
Neurontin, Zonegran, Paxil, Amitriptyline, Nortiptyline, Pamelor, Elavil, Prozac		☐ YES ☐ NO	☐ YES ☐ NO
Other	Please List:_____	☐ YES ☐ NO	☐ YES ☐ NO

TREATMENTS	RECEIVED	DID THIS HELP?
Physical Therapy/Exercise	☐ YES ☐ NO	☐ YES ☐ NO
Chiropractic Care	☐ YES ☐ NO	☐ YES ☐ NO
Injections in Muscles or other injections in office	☐ YES ☐ NO	☐ YES ☐ NO
Epidural Steroid Injections	☐ YES ☐ NO	☐ YES ☐ NO
Facet Blocks	☐ YES ☐ NO	☐ YES ☐ NO
Braces/Corsets	☐ YES ☐ NO	☐ YES ☐ NO

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Back Surgery: ☐Cervical ☐Thoracic ☐Lumbar When: _____

Prior to the onset of your current problem, did you ever visit a healthcare provider for problems with your spine? ☐ YES ☐ NO If yes, please list …

PHYSICIAN NAME	**MONTH/YEAR OF TREATMENT**

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? ☐ YES ☐ NO

If yes, please list your attorney's name:_____

Patient Signature:_____

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CONSENT FOR THE USE OF CONTROLLED SUBSTANCES OR CHRONIC OPIOID THERAPY

PATIENT: _____ DOB: _____ MRN#_____

As patient at Orthopaedic Associates, you may or may not be prescribed a controlled substance for short- or long-term pain management, including opioid medication, which is sometimes referred to as narcotic analgesics. Any decision to provide YOU with a controlled substance is not done lightly and the decision to provide YOU with a controlled substance has been made because your condition is serious or other treatments have not relieved your pain.

1. **Narcotics are drugs that act like opioids, or are similar to morphine.** Such drug can include, but are not limited to, Lortab, Percocet, Demerol, Darcon, Ultram, and Tylenol #3. I am aware that I have been prescribed: _____ which is considered a narcotic medication. I fully understand the importance of taking this medication as prescribed. The risks, benefits, possible problems, and treatment alternatives related to my use of this medication have been thoroughly explained to me., My doctor has explained and discussed the risks, benefits, and possible problems with use of this controlled substances(s) which may include, but are not limited to, the risk of abuse, death, bodily harm to myself and others, physical dependence, overdose, symptoms of withdrawal, sedation, over-sedation, constipation, urinary retention, itching, and sweating.

2. **Risk of Abuse, Death, Physical Harm, Overdose, and Synergistic Effect of Other Medications.** I am aware that this drug(s) is extremely dangerous; capable of being abused, and that an overdose can be lethal. I am also aware that when this drug is taken in excess, not as prescribed, or taken in combination with other medications, alcohol, or other illegal drugs, I may put myself at great risk of harm including, but not limited to, the risk of death and respiratory depression. In other words, I may become sleepy, fall asleep, will be difficult or unable to arouse, and finally, will stop breathing. Therefore, by signing below, I agree to take the above-referenced medication as prescribed by this practice and only as advised by my physician. I also fully agree to inform this practice and my physician of any and all of my medications prescribed by any other physicians.

3. **Risk Physical Dependence and Withdrawal.** I am fully aware that this drug(s) can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills. Physical dependence is not the same as addiction. Physical dependence means that if you suddenly stop using the Drug, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky and flu-like symptoms). I understand that physical dependence can be a normal and expected result of using controlled substances or opioid therapy for a long time.

4. **Risk of Developing Tolerance to the Controlled Substance.** I am aware that tolerance to analgesics is not necessarily a significant risk for patients with chronic pain; however, it is still a risk and may occur. If I develop a tolerance, increasing doses may not always help and may cause unacceptable side effects. If I develop a tolerance or fail to respond well to the controlled substance(s) which have been prescribed to me, it may cause my physician to choose or recommend another form of treatment.

5. **Risk of Addiction.** I am aware that physical dependence is different from addiction. Although the risk of addiction is low, I am aware that the risk of addiction is associated with many controlled substances. Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and/or others. I understand that if I develop signs or symptoms of addiction, or if I am at high risk for developing an addiction based upon my history, I will be referred to an addiction specialist or psychiatrist. Should I not agree to such a referral, I understand that I may be discharged from the practice.

6. **Other Side Effects and Risks.** There are numerous side effects which can occur because of the use of a controlled substance. These side effects include, but are not limited to:

    a. **Sedation.** If I experience this side effect, even slightly, I understand that I am not to be involved in any activity that may be dangerous to myself or someone else. Such activities include the use of heavy equipment, operating a motor vehicle, working at unprotected heights or being responsible for another individual who is a minor or is unable to care for themselves. If confusion, mental changes, or excessive sleepiness occur, report this to your physician or present to the nearest hospital's emergency department immediately,

    b. **Constipation.** If this occurs, you will not adapt to this effect. You should drink eight (8) eight-ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement, and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.

    c. **Urinary retention.** This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.

    d. **Itching.** These drugs can cause itching in some patients.

    e. **Sweating.** Profuse sweating can occur at any time with the use of these medications.

    f. **Nausea and vomiting.** If this occurs, notify your physician.

    g. **Decreased sex drive.** (See below for further details)

    h. Mild suppression of the immune response.

7. **MALES ONLY:** I am aware that the use of controlled substances has been associated with low testosterone levels in males. I am aware that this may affect my mood, stamina, and sexual desire, as well as physical and sexual performance. I understand that my physician may make a referral to a specialist for further evaluation should I develop any of these symptoms.

8. **FEMALES ONLY:** If I plan to become pregnant or believe that I have become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call this practice and my obstetrician/gynecologist. I am aware that l should I carry a baby to delivery while taking this medicine, the baby may be physically dependent on opioids, I am aware that the use of opioids is not generally associated with a risk of birth defects, as birth defects can occur whether or not the mother is taking any opioids or medications. However, the risk of birth defects is always a possibility when I am taking an opioid or any other number of medications.

9. **Substance Abuse Agreement.** I understand that along with this consent, I am required to read and abide by the terms of the Substance Abuse Agreement and Protocol that is in place at this practice if I am to be maintained on any controlled substance for a significant length of time or as a treatment for chronic pain. Should I fail to adhere to the Substance Abuse Agreement, I understand that I will be discharged from this practice.

By signing below, I consent to receive the controlled substance(s) or chronic opioid therapy referenced above, I certify that I have read this consent or have had it read to me in a language that I understand; I have had an opportunity to ask questions; that all my questions have been answered to my satisfaction; and that I knowingly and willingly give my consent to receive this medication and wish to proceed with the use thereof. I understand the risks, benefits, cautions, potential problems, and alternatives, and I give my full consent to receive this medication and understand that I must take the above-referenced medication as prescribed by my doctor.

_____ _____
Patient Print Name Date:

_____ _____
Patient Signature Date:

_____ _____
Signature Of Witness: Date:

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SUBSTANCE ABUSE PROTOCOL AND AGREEMENT

Patient: _____ DOB: _____ MRN# _____

As a patient at Orthopaedic Associates, you may or may not be prescribed a controlled substance, including opioid medicine, sometimes called narcotic analgesics, for pain management. Any decision to provide you with a controlled substance is not done lightly and the decision to provide you with a controlled substance has been made because your condition is serious or other treatments have not relieved your pain. If you are prescribed a controlled substance, we ask that you agree to our controlled substance abuse protocol. If you will not accept our protocol or fail to follow the terms of this substance abuse agreement; we cannot treat YOU and you will need to work with another physician. **Any violations of this protocol will result immediate dismissal from our practice**, as necessary.

Controlled substance medications (i.e., opioids, narcotic analgesics, tranquilizers, and barbiturates) are very useful; however, they have high potential for misuse and are therefore closely controlled by our office as well as local, state, and federal governments. They are intended to relieve pain to improve function, and/or ability to work, not simply to feel good. By signing below, I acknowledge and agree to the following:

1. I will be prescribed a thirty (30) day supply of my medication(s) which will not be filled earlier than one (1) month.
2. I am responsible for my controlled substance medications. If my medication is lost, misplaced, stolen, or used sooner than prescribed, I understand that it will not be replaced.
3. I agree to provide copies of all my medical records from previous and current physicians as requested.
4. I agree to provide a full and current medical history to my physician at Orthopaedic Associates, including any personal history and/or family history of substance abuse.
5. I agree to provide a full and current list of medications to my physician at Orthopaedic Associates and to any other physician who provides me with medical care or treatment.
6. I will not request or accept controlled substance medication from any other physician or individual while I am receiving medication from the physicians affiliated with Orthopaedic Associates.
7. I understand that my physician may have access to a record of the controlled substances prescribed to me through participation in E-FORCSE or through communication made directly to my physician by various pharmacies. If it is determined that I have received prescriptions from other physician(s) in violation of this agreement or have attempted to obtain medications from multiple pharmacies improperly, I understand that I will be immediately discharged from this practice.

8. My medication will be kept in a locked location in the original containers from the pharmacy for each medication.
9. If requested, I will bring the original containers of all medication prescribed to me, even if there is no medication remaining.
10. Refills of controlled substance medication will be made only during regular office hours, Monday through Friday, 8 am to 4 pm, Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead if I need assistance with a controlled substance medication prescription. Refill calls made on Friday will be filled and addressed the following week.
11. Refills of controlled substance medications will not be made if I “run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
12. I understand that refills of my controlled substance medications will not be made as an "emergency”, and that a follow up visit to the office will likely be required for a refill. (i.e., on Friday afternoon because I suddenly realize I will "run out tomorrow").
13. I understand that no trustworthy physician-patient relationship can be present when a patient abuses illegal drugs. The use of "street drugs" such as marijuana, cocaine, amphetamines, etc., are dangerous and illegal in this state. I understand that mixing any of my medication prescribed for pain management with "street drugs," may be lethal. Therefore, use of any "street drugs" during the course of the physician-patient relationship will not be tolerated at this practice. I understand that discovery of my use of illegal "street drugs" will result in immediate dismissal from the practice.
14. I understand that I will be submitted to random drug screens during the course of my use of controlled substance medications. If my urine drug screen test is positive for any medication not prescribed as part of my pain management therapy by this practice, I will be discharged as a patient at the discretion of my physician.
15. Also, upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of Orthopaedic Associates to discontinue my narcotic pain medication or discharge me from the practice.
16. Under Florida law, I understand that I am obligated, at minimum, to follow up with my physician at three (3) month intervals to assess my condition and treatment plan. I will attend these visits and understand that my failure to attend a follow-up appointment may result in my discharge from the practice, depending on the circumstances surrounding the scheduled visit.
17. I understand that I may be referred to an addiction specialist or psychiatrist, if indicated, during my use of controlled substances. If I refuse such a referral or fail to follow through with a referral to an addiction specialist or psychiatrist, I will be discharged from the Practice.

18. I understand that my physician may recommend alternative therapies and treatment modalities to treat my chronic pain in an effort to reduce or limit my long-term reliance on and/or tolerance to controlled substances. As a patient of this practice, I will remain open to these alternative treatment recommendations.
19. I also acknowledge that my physician may require diagnostic imaging studies during the course of my care, and I agree to obtain such studies as recommended by my physician. If I fail to follow any physician orders for such recommendations, I understand that I may be discharged from the practice.
20. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following my doctor's instructions regarding my healthcare.

I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from Orthopaedic Associates. I understand that if I violate any of the rules or terms of this agreement, I will be discharged from the Practice.

_____ _____
Patient Print Name Date

_____ _____
Patient Signature Date

_____ _____
Employee Witness Date