

Patient Consent Form

PATIENT INFORMATION				
LAST NAME		FIRST NAME		M.I.
SSN	DATE OF BIRTH	SEX	MRN	
STREET ADDRESS				
STREET ADDRESS CONTD.				
CITY		STATE	ZIP CODE	
HOME PHONE	CELL PHONE	IL	EMPLOYER NAME	
EMAIL				

Consent to Treat

Standard Patient Consent

SUBURBAN ORTHOPAEDICS CONSENT AND FINANCIAL POLICY

I. CONSENT FOR DIAGNOSIS AND TREATMENT

I am visiting Suburban Orthopaedics voluntarily for the purpose of diagnosis and medical or surgical treatment and consent to authorize diagnostic procedures and medical surgical x-ray or consultation by my physician/surgeon or physician assistant as are necessary in their judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination while visiting Suburban Orthopaedics.

II. RETENTION OF INFORMATION

I understand that Suburban Orthopaedics may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by Suburban Orthopaedics for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified in-house personnel for the purpose of conducting statistical data, management of financial audits, licensure and program evaluation or any similar purpose. I will not be identified by name or personally identifying information in any reports of such audit or evaluation without my expressed consent.

III. RELEASE OF INFORMATION

I hereby authorize Suburban Orthopaedics to release any medical or financial information concerning my treatment to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, intermediaries or any billing or collection agents associated with Suburban Orthopaedics in order to obtain reimbursement on my behalf. Further, I authorize Suburban Orthopaedics to release any medical information concerning my treatment to physicians and clinicians associated with the practice who are my healthcare providers. I may revoke my consent at any time for any reason by providing written notice to Suburban Orthopaedics. This authorization shall not conflict with any internal practices/policy regarding release of information, which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

IV. ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

In consideration of Medical Services provided to me by Suburban Orthopaedics I hereby assign Suburban Orthopaedics, its physicians and other professionals associated with the practice all of my rights and claims for reimbursement. Under Medicare/Medicaid or group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay Suburban Orthopaedics and the physician and other professionals associated with the practice the balance due of all charges not paid for the above-mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include cost of collection and/or reasonable attorney's fees. In addition, I understand that Suburban Orthopaedics maintains the right to apply a \$30.00 late fee to my account in the event any account balance for which I am

Patient Consent Form

responsible falls 60 days or more past-due.

I have read each of the foregoing I-IV and fully agree to each of the statements and agreements herein, by signing below as my free and voluntary act.

Witness Signature

Patient / Agent / Guardian Signature

Date

Medication Contract

Medication Contract

I understand that the medical treatment I receive may include opioid medicine, also known as narcotics, pain medicine, analgesics, and/or sedative medications. I understand and agree with the following:

1. Opioid and/or sedative therapy will not cure my underlying disease or condition.
2. The goals of these medications are to increase my activities at home and/or work and decrease my pain symptoms and behavior within the time specified in my treatment plan.
3. Chronic pain represents a complex problem that may benefit from physical therapy, surgery and behavioral medicine treatments. My active participation in the management of my pain is extremely important. I will actively participate in all pain management treatments prescribed by the providers at Suburban Orthopaedics.
4. Opioid, and/or sedative medications may be addictive, and abuse of these drugs may have harmful effects on my health. Common side effects that are related to opioid medication are: nausea and vomiting, drowsiness, itching, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, constipation and the possibility that the medicine will not provide complete pain relief. It is my responsibility to notify my medical provider for any side effects that continue or are severe (i.e. sedation or confusion).
5. 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 time might be slowed. Such activities include but are not limited to: operating heavy equipment or a motor vehicle, working while operating machinery or around dangerous equipment, or being responsible for another individual who is unable to care for him/herself.
6. I will not obtain an opioid or sedation medications from any source other than the providers at Suburban Orthopaedics. If I require emergency treatment that requires opioid or sedative medications I will notify my provider Suburban Orthopaedics the next business day.
7. I will receive all medications from one pharmacy. If I change pharmacies I will immediately notify the providers and staff at Suburban Orthopaedics of that change. I will furnish the providers and staff at Suburban Orthopaedics with the name and phone number of this pharmacy for the purpose of random verification of prescriptions.
8. I authorize the providers and staff of Suburban Orthopaedics to communicate with and provide this contract to my pharmacy and my other physicians.
9. Lost or stolen medications and/or prescriptions may or may not be replaced. It is my responsibility to report lost or stolen medications to the police.
10. I understand the opioid medication is strictly for my own use. The medication should never be given to others.
11. All medications are to be taken strictly as prescribed for dosage and frequency. I understand that increasing my dose without close supervision of my physician could lead to drug overdose causing severe sedation, respiratory depression and death. Decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms my include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, goose bumps, abdominal cramps and diarrhea. These symptoms can occur after the last dose and can last up to 3 weeks.

Medication Contract

12. I will not use any illegal substances, including but not limited to unprescribed narcotics, cocaine, etc.
13. I will notify my medical provider before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Soma, Xanax, Fiorinal) and antihistamines (drugs like Benadryl). I understand the combined use of the above drugs and opioid may produce profound sedation, respiratory depression, blood pressure drop, and death.
14. Urine or blood drug screens may be performed by the providers at Suburban Orthopaedics to monitor drug usage.
15. Refill request must allow 3 business/working days to fill the request. No requests will be filled on evenings, Fridays, Saturdays, Sundays or Holidays, UNDER ANY CIRCUMSTANCES.
16. Any specific medication warning must be followed, i.e. drowsiness.
17. Office visits as scheduled by the providers at Suburban Orthopaedics must be kept in order to continue receiving refills on your prescribed pain medication.

I understand that if I have a problem or question regarding any of the information provided in this agreement I must make an appointment to discuss this

Patient Consent Form

with a medical provider at Suburban Orthopaedics to clarify information **BEFORE A PROBLEM OR CRISIS SITUATION ARISES.**

In particular, if I have had a history of drug or alcohol abuse I must discuss this with a medical provider at Suburban Orthopaedics before being prescribed medication by said provider.

I understand that the providers at Suburban Orthopaedics will cancel my contract if I fail any part of the above agreement. Upon cancellation of my contract the providers at Suburban Orthopaedics will wither stop or taper me off my medications as necessary. A drug-dependence treatment program may be recommended.

I have read and understand this contract. A copy of this signed contract has been given to me for reference. All of my questions have been answered in a satisfactory manner. I understand my compliance with this contract is mandatory to continuing my medication treatment with the providers at Suburban Orthopaedics. I consent to the use of medication in the treatment of my pain as outlined in this contract.

Witness Signature

Patient / Agent / Guardian Signature

Date

Bloodwork Consent

Needlestick Bloodwork Consent.

I hereby agree to have bloodwork drawn to test for bloodborne pathogens (hepatitis B, hepatitis C, or HIV) if an exposure occurs (needlestick injury, blood spatter) to one of the staff. I have been fully informed of the reason for this bloodwork, and I understand what I am being tested for and the procedure involved. I am fully aware that the test results will be forwarded to my provider and will become a confidential part of my record. Testing will be done at no cost to you.

Witness Signature

Patient / Agent / Guardian Signature

Date