Patient Registration Form

Date: _____ **Email Address:**_____

Name: _____ **DOB**_____ **Phone**_____

Address: _____ **City**_____ **State**____
Zip_____

Sex_____ **Martial Status:** M D S W **Drivers License** _____**SS#**_____

Emergency Contact_____ **Emergency #**_____

Guarantor Information (who is responsible for you if not yourself?)_____

Guarantor relationship to you:_____ **Guarantor's Phone #**_____

Chronic Medical Conditions: _____

Primary Insurance Name_____ **Primary #**_____

Secondary Insurance_____ Secondary #_____

Pharmacy _____

Allergies_____

I have read and understand the HIPAA Privacy Policy for Family Medical Clinic that has been provided to me in the lobby and am entitled to a copy of this notice at any time that I request a copy.
I understand that I am responsible for any balances on my account, even if insurance fails to pay.
I agree that the clinic may communicate with me via the email address that I have provided.
I authorize Family Medical Care to use and release my demographic and medical information to any party related to my healthcare, including insurance carriers, other physicians/facilities, attorney, etc..
I understand that it is my responsibility to keep my appointment time and that I must give notice of cancellation at least 24 hours prior to my scheduled appointment or else a $60 late fee will apply after 2 no show appointments.
I agree that all co-pays are due at the time of service and that I must make consistent monthly payments on my account if any balance if owed.
I will take all medications as prescribed by the provider without unprescribed medications in addition.
I understand that all refills must be ordered by my pharmacy via fax.
I consent to random drug testing if I am prescribed a controlled substance.
I understand that I am responsible for my medications.
I agree to comply with the plan of care that my provider prescribes for me.
I authorize the clinic to speak with _____ at _____ about my personal information.

Signature_____

Signature of Guarantor (if applicable)_____

Medication List

FAMILY MEDICAL CARE CONTROLLED SUBSTANCE PATIENT AGREEMENT

I, _____, understand and voluntarily agree that (initial each statement after reviewing).

_____ I will keep and be on time for all my scheduled appointments with the provider(s) and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in such as physical therapy, psychiatric assessments or drug addiction programs.

_____ I will keep my medication(s) safe, secure and out of reach of others. If the medication(s) is lost or stolen I understand that the medication(s) will NOT be replaced until my next regularly scheduled appointment and cannot be replaced by another provider outside this office.

_____ I will take my medication(s) as prescribed and not change or increase without the approval from the provider(s)

_____ I will NOT call between appointments including after hours and weekends requesting refill(s) of controlled medication(s). I understand that the prescription(s) will be filled only during office appointments.

_____ I understand that my medication(s) will be sent to my pharmacy on file within 24 hours of my scheduled appointment.

_____ I will make sure that I have scheduled my next office appointment before leaving the office. If I have trouble making follow-up appointments, I will tell a member of the treatment team immediately.

_____ I will always TREAT THE STAFF of Family Medical Care and its associates with respect. I understand that if I am disrespectful to any member of the staff or disrupt the care of other patients, I will risk termination from this practice.

_____ I will NOT sell or give to others my medication(s) for ANY reason. If this is discovered I will be terminated from this practice.

_____ I will sign a release form to let the provider(s) speak to all other providers or pharmacies that I have sought care from in the past or presently to obtain medical history prevalent to my current treatment and care by this practice.

_____ I will tell the provider(s) or care team all medication(s) prescribed or taken over the counter and that I will advise the provider(s) or care team of any medication changes at my office appointment.

_____ I will use only ONE LOCAL pharmacy to fill controlled medication(s) from this practice

PHARMACY:_____

CITY:_____

_____ I will NOT obtain ANY OTHER controlled medication(s) from any other provider (this includes dental or emergency department) without written permission from the provider(s). Hospitalization requires a discharge report within 72 hours of discharge so that it can be documented in my medical chart.

_____ I will NOT use illegal drugs such as methamphetamine, cocaine, heroin, ecstasy or non-prescribed amphetamine for ANY reason. If these drugs appear on my monthly drug screen, I will be immediately discharged from my controlled substance program with this office.

_____ I will come for random controlled substance screening and/or pill counts within 4 hours notification. I will always have a working contact number and emergency contact number on file with this practice. A missed call or disconnected number will not be accepted as an excuse. If I fail to come within the allotted time, I understand that I will no longer receive controlled substances from this office.

_____ I will come for drug screening every 30 days and see the provider in the office to receive a refill prescription(s). If I am more than 7 days late to a follow up appointment this will be considered an abnormal drug screen and risk no longer receiving controlled medication(s) from this practice. Advance notice or hospitalization will be the only accepted excuse from missing my monthly drug screen and office appointment. Advance agreement must be documented in my chart by the provider(s).

_____ I will test positive for the controlled medication(s) that I am CURRENTLY prescribed by this practice on my monthly drug screen. An abnormal drug screen will be disciplined, and I will risk termination from further controlled substance prescriptions from this practice.

FAMILY MEDICAL CARE CONTROLLED SUBSTANCE PATIENT AGREEMENT

_____ I will keep up to date with my bills with this practice and I will advise the office manager or billing department immediately if I lose or change by insurance or if I cannot pay for my treatments.

_____ I understand that I may lose my right to treatment or medication(s) if I break any part of this agreement.

_____ If I have an addiction problem the provider(s) may ask me to follow through with a program to address this issue. Such as a 12-step program, counselling or inpatient or outpatient treatment.

_____ I understand that the provider(s) may stop prescribing controlled substances or change my treatment program if I do not show improvement in pain or my physical activity has not improved, my behavior is inconsistent, I develop rapid tolerance or loss of improvement from treatment, unable to keep follow-up appointments or develop an addiction to my controlled medication(s).

Safety risks while working while taking controlled substances.

We at Family Medical Care are concerned for your safety risks while working under the influence of controlled substances. You should be aware of potential side effects such as decreased reaction time, clouded judgement, drowsiness, and tolerance. Also, you should know about the possible danger associated with the use of controlled substances while operating heavy equipment or while operating a motor vehicle. A Narcan prescription will be given when you start controlled substances from this practice and renewed yearly. The Arkansas PMP will be checked so see if you have filled the Narcan prescription. Controlled substances will not be refilled until verification that you have filled the Narcan prescription. This is for your safety and others who come into your home.

Side effects such as confusion, nausea, constipation, vomiting, poor coordination, falls, sleepiness, decreased respiration, aggravation, irritation, depression and dry mouth. These symptoms may be worse when taking multiple medications or taking with alcohol.

Risks of chronic use of controlled medications include physical dependence with the symptoms of runny nose, abdominal cramping, rapid heart rate, diarrhea, sweating, nervousness, difficulty sleeping and goose bumps.

Psychological dependence will cause cravings when a medication is discontinued.

Tolerance is when you require more and more medication to attain the same effect.

Addiction is when you develop a compulsive, chronic, physiological or psychological need for a habit-forming substance, behavior, or activity having harmful physical, psychological, or social effects and typically causing **well-defined** symptoms (such as anxiety, irritability, tremors, or nausea) upon withdrawal or abstinence.

If you are pregnant or planning on becoming pregnant a discussion on the safety of your current medication(s) must be taken with the provider(s).

Keep a diary of the controlled substance(s) you are taking, the dose, time of day you are taking them, their effectiveness and any side effects you may be experiencing.

Use of a medication box that you can purchase at a pharmacy that is already divided into days of the week and times of day so it is easier to remember when to take your medications and prevent an over dose.

When travelling only take the amount needed for the time you will be away from home. This will reduce the chance of losing ALL of your medication(s) at once.

Current and accurate treatment records will be required at all times. Such as MRI/CT scans that are no more than 36 months old, x-rays that are no more than 12 months old. Physical therapy records that are no more than 24 months old. All surgical records that pertain to your treatment. Documentation of mental health assessments if needed for your care and treatment.

I have read this contract, understand and have had all my questions answered satisfactorily. I consent to the use of controlled substance(s) to help in the treatment of my medical condition and I understand that my treatment will be carried out as described in this contract.

FAMILY MEDICAL CARE CONTROLLED SUBSTANCE PATIENT AGREEMENT

Date _____ Patient Signature _____

PHILIP **ELANGWE** M.D. _____ _____ _____

Provider name Provider signature Date

CONTROLLED SUBTANCE TREATMENT PROGRAM STATEMENT

We here at Family Medical Care are making a commitment to work with you in your efforts to improve your health. To aid in attaining your goals we agree that:

We will help you schedule regular appointments for medication refills. If our office must cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will keep track of your prescription(s) through your medical records and the Arkansas and Oklahoma PMP Aware program (reported by pharmacies for controlled medications) and drug test you monthly to assure that we are meeting safety guidelines set by the Drug Enforcement Agency (DEA), the Arkansas State Medical Board and the Arkansas Department of Health to assure that we are monitoring your health and safety well.

We will help connect you with other forms of treatment to help with your condition. We will help set treatment goals and monitor your progress in achieving your health goals.

We will work with other providers you are currently under treatment with so that we can work together as a team effectively.

If you become addicted to any of the medications prescribed to you, we will help you in locating treatment for your addiction.

Philip Elangwe M.D.