

# BAPTIST HOSPITAL, INC. – CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.

- a. I recognize that I have a condition requiring medical care, and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Hospital, Inc. (the “Hospital”), as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care, any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist.
- b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.
- c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.
- d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.
- e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL’S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital’s charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers’ compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.

3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids, I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.

4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.

5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges



6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records, required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physicians involved in my care for any services furnished me by the Hospital and said physicians.
7. Indigent Drug Program. If I qualify and accept assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications.
8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.
9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.
10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.
11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.
12. Patient Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

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Patient or Patient's Representative (if patient is minor or unable to sign)      Relationship to Patient      Date and Time

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Witness

If patient is a minor, the parent must also complete the following:

The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

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Guarantor      Date and Time

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Guarantor (Print Name)

# Baptist Medical Group

## Patient Consent and Responsibility Agreement

**Welcome to Baptist Medical Group (BMG). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.**

**CONSENT FOR TREATMENT.** I consent to all services as ordered or performed by my BMG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

**OBLIGATION TO PAY MY BMG BILL:** I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

**MEDICAL INSURANCE:** I authorize BMG to bill my health plan or other applicable insurer or third party payor and I assign to BMG all of my rights and claims for reimbursement by a third party payor. I authorize BMG to release to all third party payors any medical information that is required in order for BMG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

**APPOINTMENTS:** I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a \$25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

**AUTHORIZATIONS AND REFERRALS:** I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

**FINANCIAL ASSISTANCE:** I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 469-2000 to request financial assistance or access the policy and application at <https://ebaptisthealthcare.org/PatientFinancialResources>. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.



**RETURN CHECK POLICY:** I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

**BUSINESS HOURS:** I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

**PRESCRIPTIONS AND/OR REFILLS:** I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

**PATIENT FORMS COMPLETION:** I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

**PATIENT PORTAL:** I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at <https://ebaptisthealthcare.org/PatientPortal>.

**WIRELESS COMMUNICATION:** By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

**NOTICE OF PRIVACY PRACTICES:** I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

**BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BMG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.**

<b>Patient/Personal Representative Signature</b>	<b>Date</b>
<b>Print Patient/Personal Representative Name</b>	<b>Personal Representative's relationship to patient:</b>

# PATIENT REGISTRATION FORM

## ***PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** \_\_\_\_\_

**Race:**  American Indian or Alaska native  Asian  Black or African American

Native Hawaiian or other Pacific Islander  White  Unknown/Declined to answer

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Unknown/Declined to answer

Home phone: (\_\_\_\_\_) \_\_\_\_\_ cell phone: (\_\_\_\_\_) \_\_\_\_\_ work phone: (\_\_\_\_\_) \_\_\_\_\_

Best daytime number to reach you:  home  work  cell Is it ok to leave a message at any of the numbers?  Yes  No

If no, please designate which ones, if any: \_\_\_\_\_

Primary Care Physician's Name (if applicable): \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Spouse's SS#: \_\_\_\_\_

## ***RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL***

Relationship to Patient:  Self (skip to next section)  Parent  Spouse  Other (skip to next section) \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth date (mm/dd/yyyy): \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_

## ***INSURANCE INFORMATION***

**Primary Insurance Coverage:** \_\_\_\_\_ Copay: \$ \_\_\_\_\_

Policy effective date: \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Met?  Yes  No If no, amount met: \$ \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_

**Secondary Insurance Coverage:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_



## Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant **verbal discussions** regarding my health care. By signing this form, I permit Baptist Medical Group (“BMG”) staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

- I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.
- I understand that information may be released to family members or others without this form, if allowed by federal and state law.
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.
- I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.
- I can update this form at any time by completing a new form and giving it to BMG staff.
- I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.
- **I understand that this is *not* a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information.**

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Name:

Phone #:

Relationship:

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Name:

Phone #:

Relationship:

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Name:

Phone #:

Relationship:

---

Name:

Phone #:

Relationship:

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Relationship to Patient:

- Self  
 Legal Representative or Guardian (*proof of power of attorney or legal guardianship required*)

Baptist Medical Group  
Family Members and Friends Involved in Patient Care (08-16)  
FM-0430 Pg. 1 of 1



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*brahim, M.D.*  
*Nicholas Drake, M.D.*  
*Simon Zeichner, D.O.*

*Rhonda Campbell, APRN*  
*Jessica Nichols, APRN*

### Hematology-Oncology

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Please describe the reason why your physician sent you to our office:** \_\_\_\_\_

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**Do you suffer from any of these conditions? (Check boxes)**

- |                                              |                                       |
|----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heart               | <input type="checkbox"/> Kidneys      |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lungs        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Stomach      |
| <input type="checkbox"/> Cholesterol         | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Strokes             | <input type="checkbox"/> Thyroid      |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Other _____  |

**Prior Operations:**

_____	_____
_____	_____
_____	_____

**Medication Allergies (or those you cannot tolerate):**

_____	_____
_____	_____
_____	_____

**Current Medications:**

_____	_____
_____	_____
_____	_____
_____	_____

**Do you use tobacco, including smoking or smokeless tobacco?**  Yes or  No

*\* If you answered yes, please circle the type of tobacco you use:*

Cigarettes                      Chewing tobacco                      Cigars

*\* If you answered yes, have you ever tried to quit using tobacco?*  Yes or  No

How many years ago? \_\_\_\_\_

**What is your daily caffeine intake (coffee, soda, tea)?** \_\_\_\_\_

**Do you use alcohol?**  Yes or  No *If so, how frequently?* \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Please check the boxes which apply to you:**

**General**

- Anorexia
- Chills
- Fever
- Malaise/Fatigue
- Weight Loss
- Feeling Well
- Compliance with Diet
- Dietary Changes
- Medication Changes

**Eye**

- Itching
- Lacrimation
- Pain
- Photophobia
- Vision Changes
- Discharge
- Visual Disturbances
- Dryness

**Mouth/Throat**

- Dysphagia
- Hoarseness
- Lesions
- Rash
- Throat Pain
- Coated Tongue/  
Mucous Membranes
- Dental Problems
- Sore Throat
- Voice Changes
- Dryness

**Skin**

- Icterus
- Lesions
- Pruritus
- Rash
- Varicose Veins
- Normal
- Skin Color Change
- Tattoo/Piercing

**Ear**

- Discharge
- Hearing Disturbance
- Hearing Loss
- Pain
- Tinnitus
- Pulling Ear

**Respiratory**

- Cough
- Dyspnea
- Hemoptysis
- Pleuritic Chest Pain
- Wheezing
- Difficulty Breathing on  
Exertion
- Shortness of Breath at Rest
- Sputum Production

**Breast**

- Breast Lump
- Nipple Discharge
- Tenderness
- Swollen Glands
- Swelling
- Nipple Pain
- Recent Breast Changes

**Nose**

- Congestion
- Discharge
- Nose Bleeds
- Obstruction
- Sneezing
- Decreased Sense of Smell
- Running Nose

**Cardiovascular**

- Chest Pain
- Claudication
- Lower Extremity Swelling
- Orthopnea
- Palpitation
- Fainting
- Feels Faint at Times
- Irregular Heart Beat



Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### **Gastrointestinal**

- Abdominal Pain
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Black Tarry Stool
- Change in Bowel Habits
- Difficulty Swallowing
- Heartburn
- Indigestion
- Mucous in Stool
- Stool Incontinence

### **Gastrorectal**

- Change in Bowel Habits
- Hematochezia
- Melena
- Rectal Pain
- Stool Incontinence

### **Genitourinary**

- Dysuria
- Hematuria
- Sexual Dysfunction
- Urinary Frequency
- Urinary Hesitance
- Urinary Incontinence
- Change in Bladder Habits

### **Gynecological**

- Change in Menes
- Dyspareunia
- Vaginal Discharge
- Vaginal Pruritus
- Vulvar Swelling

### **Neurological**

- Confusion/Memory Loss
- Dizziness
- Headache
- Numbness
- Weakness
- Change in Consciousness
- Unsteadiness
- Change in Speech
- Difficulty Speaking
- Difficulty with Ambulation
- Tingling
- Loss of Balance
- Seizures
- Unusual Sensation

### **Psychiatric**

- Anxiety
- Depression
- Hallucinations
- Insomnia
- Mood Problems
- Fearful
- Suicidal Ideation
- Delusions

### **Musculoskeletal**

- Pain in Joints
- Back Pain
- Joint Swelling
- Pain
- Stiffness
- Joint Redness
- Muscle Pain/Myalgia
- Muscle Weakness

### **Heme/Lymph**

- Bleed/Bruise Easily
- Enlarged/Tender Lymph Nodes
- Night Sweats
- Abnormal Bleeding
- Anemia

### **Endocrine**

- Change in Weight
- Cold/Heat Tolerance
- Hot Flashes
- Polydipsia
- Polyuria
- Appetite Changes

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

## CONTROLLED SUBSTANCE AGREEMENT

The State of Florida has laws governing the prescription of controlled substances. These drugs include all opioids (such as codeine, hydrocodone and oxycodone), sleeping aids, benzodiazepines (such as Valium, Xanax and Ativan) and ADHD medications (such as Concerta, Metadate CD, Ritalin and Vyvanse). To comply with Florida law, I acknowledge and agree to the following:

Prescriptions for most controlled substance medications can only be written for a 30 day supply.

I will not use any illegal controlled substances, such as marijuana and cocaine.

I will not share, sell or trade my medication with anyone.

I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written or filled, will not be replaced.

I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. If requested by my doctor, I will bring all unused pain medicine to every office visit.

I will request refills of my controlled substance only during an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I must be seen by my doctor no less than every 3 months to continue to get refills.

I will submit to a blood or urine test within 24 hours of when requested by my doctor to determine my compliance with these policies and my program of pain control medicine.

I will communicate fully and truthfully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

I will obtain all controlled medicines **only** from the physician listed below. If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to this office in the original bottle, even if there are no pills left.

I acknowledge controlled substance medications have inherent risks associated with their use. These risks include but are not limited to the following: Physical dependence, Psychological dependence, potential for overdose, and potential for withdrawal syndrome.

I agree to comply with the terms of this agreement. I understand that my physician has the right to discontinue prescribing me controlled substance medications and discharge me from care if I do not comply with the terms of this agreement. I hold Baptist Medical Group and its staff harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement.

I agree to use \_\_\_\_\_ (pharmacy), located at \_\_\_\_\_ (address) for filling prescriptions for all of my controlled substance medications. If my pharmacy location changes, I will promptly notify the office.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

