Southern Orthopaedics & Sports Medicine, P.A.

****All office locations can be reached toll free (866) 432-3293****

Attached are our new patient information forms which we must have completed for your chart. If you have been in previously or are being seen for a new problem, we require that these forms be updated on a yearly basis.

Please complete these forms prior to your appointment and bring into the office with the following items:

1. Any x-rays concerning this condition.
2. Referral authorization number if you have any HMO insurance or Tricare Prime. (This authorization must come from your Primary Care Physician).
3. Any doctor's notes concerning this condition.
4. All insurance information:
   a) Insurance cards (we will need to copy them.)
   b) If auto related, we require your claim number, date of accident, policy holder's name, agent, insurance company name, address and phone number.
   c) If work related, we require worker's compensation carrier address and phone number with contact person, claim number, and date of accident, prior to the appointment being scheduled.
5. In order for the doctor to provide the best care possible he needs to know what has previously been done for your condition. If you fail to bring in any of the needed information it will be necessary to reschedule your appointment for another time when you have gathered all of the required information.
6. Please bring in a list of all current prescribed medications and dosages.
7. We will collect all insurance co-payments at the time of the visit.
8. If you have no insurance, we will require full payment at time of visit unless you have made prior arrangements with our billing office.
9. If you have any questions, please feel free to call 432-3293 or 866-432-3293.
10. Please come to our office with the above information 30 minutes earlier than your appointment time in order for our patient specialist to enter this information into the computer system and prepare your chart for your appointment thus preventing a delay in getting you in to see the doctor at your designated appointment time.

Thank you for your cooperation, and for choosing Southern Orthopaedics & Sports Medicine.

PATIENT INFORMATION

Date _____

Last Name_____First_____Middle_____

Preferred Name _____

Age _____ Date of birth _____ Sex ☐ M ☐ F SS#_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other _____

Address _____

City _____ State _____Zip_____

Home phone _(____)_____ Work phone _(____)_____

Cell Phone _(____)_____ Email _____

Spouse Name _____ Phone Number _____

Who is your Primary Care Physician? _____

How did you hear about our practice? _____

Reason for today's visit: _____

Place of Employment: _____

If injury, give date _____ or date of first symptoms _____

Please circle where the Injury occurred:

JOB AUTO HOME OTHER

Have X-rays been taken? ☐ Yes ☐ No When?_____ Where?_____

PAYMENT INFORMATION

Name of person responsible for payment _____

Do you have insurance coverage? ☐ Yes ☐ No

PRIMARY INSURANCE _____

Policy holder _____

Policy holder's ID# _____

Policy holder's Group # _____

Policy holder's date of birth _____

Policy holder's Social Security Number _____

SECONDARY INSURANCE _____

Policy holder _____

Policy holder's ID# _____

Policy holder's Group # _____

Policy holder's date of birth _____

Policy holder's Social Security Number _____

Welcome to our practice. Please fill out the information below to the best of your ability.

Today's Date: _____

Patient's Name _____ Age _____ Date of Birth _____ M / F

Chief Complaint _____

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check all pertinent boxes.

- ☐ Aids or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infections
- ☐ Bleeding Tendency
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer

PAST SURGICAL HISTORY

Please list previous Hospitalizations / Surgeries / Serious Illnesses When? Hospital, City, State

_____

_____

_____

_____

MEDICATIONS

Please include non-prescription and Herbal Supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

ALLERGIES

Medication	Reaction	Medication	Reaction

Tape Allergy ☐ Yes ☐ No **Latex Allergy** ☐ Yes ☐ No

FAMILY HISTORY

Things that members of your family have

- ☐ Back Pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Sudden Death
- ☐ Tuberculosis

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Separate
- ☐ Single
- ☐ Widowed

Use of Alcohol
- ☐ Daily
- ☐ Moderate
- ☐ Never
- ☐ Rarely

Use of Tobacco
- ☐ Currently
- ☐ Never
- ☐ Previously, but quit

_____
Packs per day

Living Situation
- ☐ Alone
- ☐ Other

_____
- ☐ With Family
- ☐ With Friends

Dominant Hand
- ☐ Right
- ☐ Left

Date	Date	Date	Date	Date	Date
Patient	Patient	Patient	Patient	Patient	Patient
Doctor	Doctor	Doctor	Doctor	Doctor	Doctor

PATIENT HISTORY

The following questions pertain to symptoms the patient is experiencing or experiences on a regular basis. These questions pertain to the patient only:

CONSTITUTIONAL

Weight Loss	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Night Sweats	☐ YES	☐ NO
Problems with Anesthesia	☐ YES	☐ NO

EYES:

Metal In Eye	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO

ENT:

Nose Bleeds	☐ YES	☐ NO
Ear Ringing	☐ YES	☐ NO
Sore Throat	☐ YES	☐ NO
Hearing Loss	☐ YES	☐ NO

CARDIOVASCULAR:

Chest Pain	☐ YES	☐ NO
Leg Swell	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO
Irregular Beat	☐ YES	☐ NO
Heart Attacks	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Blood Clot Lung/Legs	☐ YES	☐ NO

RESPIRATORY:

Irregular	☐ YES	☐ NO
Shallow	☐ YES	☐ NO
Cough	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO

GASTROINTESTINAL:

Nausea/Vomiting	☐ YES	☐ NO
Change in Bowel Habits	☐ YES	☐ NO
Distension	☐ YES	☐ NO
Tarry Stools	☐ YES	☐ NO
Bloody Stools	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO

GENITOURINARY:

(Reproductive & Urinary Systems)

Frequency in Urination	☐ YES	☐ NO
Burning	☐ YES	☐ NO
Frequent Urination at Night	☐ YES	☐ NO
Frequent Infections	☐ YES	☐ NO
Bloody Urine	☐ YES	☐ NO
Inability to Control Bladder	☐ YES	☐ NO
Inability to Urinate	☐ YES	☐ NO
Prostate Problems	☐ YES	☐ NO

NEUROLOGICAL:

Fainting Spells	☐ YES	☐ NO
Seizures	☐ YES	☐ NO
Amnesia	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Headache	☐ YES	☐ NO
Paralysis	☐ YES	☐ NO
Stimulator Implant	☐ YES	☐ NO

MUSCULOSKELETAL:

Back Pain	☐ YES	☐ NO
Neck Pain	☐ YES	☐ NO
Leg Pain	☐ YES	☐ NO
Joint Swelling	☐ YES	☐ NO
Fractures	☐ YES	☐ NO
Arm Pain	☐ YES	☐ NO

ENDOCRINE

Do you have diabetes?	☐ YES	☐ NO
Do you take insulin?	☐ YES	☐ NO
Hair Gain?	☐ YES	☐ NO
Hypoglycemia	☐ YES	☐ NO
Hyperglycemia	☐ YES	☐ NO

PSYCHIATRIC

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Hallucinations	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO
Compulsive Behaviors	☐ YES	☐ NO
Impulsive Behaviors	☐ YES	☐ NO
Suicidal Ideation	☐ YES	☐ NO

HEME-LYMPH

Lightheadedness	☐ YES	☐ NO
Easy Bleeding	☐ YES	☐ NO
Easy Bruising	☐ YES	☐ NO
Petechiae	☐ YES	☐ NO
Purpura	☐ YES	☐ NO
Lymph Node Enlargement	☐ YES	☐ NO
Pica	☐ YES	☐ NO

ALLERGIC-IMMUNOLOGICAL

Sinus Allergy Symptoms	☐ YES	☐ NO
Allergic Dermatitis	☐ YES	☐ NO
Frequent Illness	☐ YES	☐ NO

PLEASE USE THIS SPACE TO LIST ANY INFORMATION THAT HAS NOT BEEN MENTIONED ABOVE THAT YOU FEEL WOULD BENEFIT THE DOCTOR IN HIS TREATMENT OF YOUR CASE.

DATE REVIEWED BY:					
DATE REVIEWED BY:					
DATE REVIEWED BY:					
DATE REVIEWED BY:					

Southern Orthopaedics & Sports Medicine, P.A.

Please list the family member or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care):

_____

Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name:_____ Phone#_____

Name:_____ Phone#_____

Print the address of where you would like your billing statement and/or correspondence from our office to be sent **IF** other than your home:

_____

Please print the telephone number where you want to receive calls about your appointments, or other health care information **IF** other than your home phone#

_____

Do you have voicemail or an answering machine? YES:_____ NO:_____

Can confidential messages (such as appointment reminders) be left on your voicemail or answering machine? YES:_____NO:_____

PATIENT NAME:_____(guardian if patient is under 18 years old)

PATIENT/GUARDIAN SIGNATURE:_____

DATE:_____

Southern Orthopaedics and Sports Medicine, P.A.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

We file an insurance claim within 7 days of your date of service.

If your appointment is not cancelled within 24 hours, you will be charged a $25.00 no-show fee.

A billing statement covering medical services rendered will be mailed to you monthly.

If we do not receive a response from your insurance carrier within 90 days, you will receive a statement and will need to contact your insurance carrier regarding payment. **The balance due for medical services will be your responsibility.**

If you have financial problem, please ask to discuss a payment plan with our staff. Our minimum payment plan begins at $25.00 per month. We accept cash, checks, VISA, or Mastercard as payment. American General Financing is also available. In the event a personal check is returned unpaid from your bank, your account will be charged a $25.00 return check fee. Please note all co pays are due at the time of service. If we must bill you for two consecutive co pays, there will be a $5.00 charge added for billing.

AUTO RELATED INJURIES

Failure to inform us that the injury related to this appointment is a result of an auto accident could revert all financial responsibility to you the patient. Insurance information must be obtained before appointment date. Failure to provide us with this information will result in the rescheduling of the appointment.

NO INSURANCE

Payment is required at the time services are rendered.

(over)

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

MINOR PATIENTS
The parent/guardian/adult accompanying a minor child is responsible for payment. Any child 18 or over is legally an adult and responsible for his/her bill, regardless of attending college, living at home, or being covered by parents insurance. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, the parent who brings the child in for services is ultimately the responsible party.

If you had a previous collection balance or are presently in collection, the physician may use his or her discretion as to seeing you again. It may be required that you pay your previous balance in full prior to being seen. You will be responsible for payment of the office visit, co pay, deductible, etc., on the day of the visit.

Surgery

If your physician recommends surgery, one of our Surgery Coordinators will contact you. They will answer specific questions about the surgery scheduling process and complete all pre-certification/authorization if your insurance company requires it.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. The Surgery Coordinator will explain a cost estimate, which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Southern Orthopaedics & Sports Medicine, P.A.

I authorize Southern Orthopaedics & Sports Medicine, P.A. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____	_____
Date	**Signature**	**Printed Name**

Southern Orthopaedics & Sports Medicine, P.A.

SOUTHERN ORTHOPAEDICS
1823 NORTH 9TH AVE.
PENSACOLA, FL 32503

(850) 432-3293 PHONE
(850) 434-7813

Consent for Treat and to Use and Disclose Protected Health Information

*Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Southern Orthopaedics and Sports Medicine for disclosure to others for the purpose of treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice.

*Notice of Privacy Practices

Southern Orthopaedics and Sports Medicine is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. PLEASE READ AND REVIEW IT CAREFULLY.

*Requesting a Restriction on the use of Your Information

You may request a restriction on the use or disclosure of your protected health information. Southern Orthopaedics and Sports Medicine may or may not agree to restrict the use or disclosure of your protected health information (see authorization).

If Southern Orthopaedics and Sports Medicine agrees to your request the restriction will be binding on the practice. Use of disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

*Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

*Reservation of right to Change Privacy Practices

Southern Orthopaedics and Sports Medicine reserves the right to modify the privacy practices outlined in the notice. I understand that Southern Orthopaedics and Sports Medicine will notify me of these changes via the method I have authorized or upon my next appointment.

*Signature

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to Southern Orthopaedics and Sports Medicine to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

SOUTHERN ORTHOPAEDICS & SPORTS MEDICINE
HIPAA POLICY MANUAL

HIPAA Privacy Policy

It shall be the policy of Southern Orthopaedics & Sports Medicine to protect and safeguard the Protected Health Information of its patients in accordance with the Privacy Regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 and applicable state laws.

The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

These Policies are intended to provide guidance to providers and employees in regard to the protection and enhancement of the privacy rights of patients by (a) establishing rules related to the internal and external Use and Disclosure of Protected Health Information; (b) affording patients access and information regarding the Use and Disclosure of their Protected Health Information; and (c) implementing administrative procedures intended to assist patients and staff to effectuate these Policies.

These Policies will apply to all Protected Health Information collected by our practice after April 14, 2003. The Policies apply to all physicians and staff of Southern Orthopaedics & Sports Medicine.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08 05

PICA | PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d

12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED | DATE | SIGNED

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | FROM | TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. | 3.

2. | 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER | SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

SIGNED | DATE

a. | b. | a. | b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sign Only

Southern Orthopaedics & Sports Medicine, P.A.

NARCOTIC AGREEMENT

The purpose for this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my doctor may stop prescribing these pain-control medications and/or release me from the practice. If this occurs, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully 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 understand that if I am being prescribed pain medication by another physician that I must notify that physician regarding medication prescribed to me by the physician listed below.
- 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 not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written, or filled, **will not be replaced**.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or weekends**.
- I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State of Florida's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this agreement to my pharmacy.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I agree that 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 agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given upon request.

I agree to use _____(pharmacy), located at_____(address)
_____(telephone number), for filing prescriptions for all of my pain medications.

Patient Name: _____ DOB: _____ Date: _____
Patient Signature:_____ Witness: _____
Physician Name: PHILIP C. BENTON, M.D.
Physician Signature: _____