Date_____ MR_____ Dr_____

FAMILY FIRST HEALTH CARE ATHENS/LAVONIA/LAKE OCONEE

Pain Management Center

New patient

Patient Name _____

Date_____ MR_____ Dr_____

Introduction: We want to welcome you to our Pain Management Clinic, where we are dedicated to providing cost effective and timely care for the local population. Our physicians specialize in the treatment of pain.

Hours of Operation: 8:00 AM- 5:00 PM Monday to Friday

Initial Visit: Your initial consultation visit takes about 1 hour and is usually an evaluation only. At your consultation visit, you will need to provide a urine drug test prior to speaking with the provider. After the physician has completed your examination, we will give you the recommendations, answer questions and talk about a plan of care; **medication is not going to be prescribed on the first visit.** After your Consultation, you will need to complete any recommended testing and a Pain Physical. Medication will then be discussed once all testing is completed.

This contract/agreement must be completed entirely before you are seen by the provider at your Consultation.

You must have the following with you at your first appointment:

Georgia Photo ID (or a Government issued ID)
Current Insurance Card (s)
Completed Paperwork
ALL Current Medications (List or Bottles)

Unfortunately, we WILL have to reschedule you if you do not have all the requested information.

Payment options:We do not accept checks- (Discover, AMEX, Master Card or Visa, Cash are all accepted)
If we participate with your insurance, we will abide by our contract with them in terms of the fee schedule and write offs required. You are responsible for any copays, coinsurance or deductibles. **Payment is due at the time of service for anything that is patient responsibility**. Failure to provide correct insurance information, in a timely manner, will result in you being responsible for our fees, in full.

This facility does NOT offer any type of payment plans.

Referrals: Should any services we provide, such as office visit or urine drug screens, require a PCP referral, it is your responsibility to obtain this. Your failure to obtain this means you will be responsible for payment for services rendered.

Authorizations: If your insurer requires authorization for procedures and/or injections we will obtain these, if possible. However, these do take time and we need at least two week notice in order to do so. If you insist on having a procedure without an authorization you will be required to make payment at time of service for the procedure. Some insurers limit the number of certain procedures during a calendar year. If you feel that you require one after this limit has been reached you may schedule one once payment, in full, has been made.

This facility does not support the use of Benzodiazepine and Narcotics. If you require this type of medication, and you are receiving Narcotics, you will need to speak with the Prescribing Doctor to get the Benzodiazepine changed to a non-controlled medication before Narcotics will be prescribed.

This facility has the right to refuse treatment without reason.

Date_____ MR_____ Dr_____

ASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing policies for Family First Healthcare Pain Management and I authorize payment of medical benefits to the Family First Healthcare Pain Management. I also authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any copay, coinsurance, deductibles, non-referred and non-covered services as outlined in my health plan.

Patient Name: _____ DOB: _____
Patient Signature: _____ Date: _____

*Under Georgia Law it is considered "Theft of Services" to obtain care by providing false insurance information.

Last: _____First: _____ Middle:_____
DOB: _____ SS#: _____ Sex: M/F Marital Status: S M W D other
Race: ☐Caucasian ☐Asian ☐African-American ☐Hawaiian ☐Hispanic ☐Other
Address: _____ Apt # _____
City: _____ State: _____ Zip Code: _____
POST OFFICE BOX:_____
Home Phone:_____OK to Leave Message: ☐Yes ☐ No
Cell Phone: _____OK to Leave Message: ☐Yes ☐ No
Email:_____

Please list one person that you authorize to receive medical information on your behalf:
_____
_____
_____
_____

1ST Emergency Contact : _____
Phone#:_____
2ND Emergency Contact: _____
Phone#:_____

- ☐ Please provide a different number other than your home and cell number.

EMPLOYER: _____ WORK#: _____

PRIMARY INSURANCE:

_____
Insurance Policy Holder Name (If other than patient):_____ Insurance Policy ID _____ DOB: _____
SSN# _____ Group #_____
Effective Date:_____

Date_____ MR_____ Dr_____

SECONDARY INSURANCE:

_____

Insurance Policy Holder Name (If other than patient):_____ Insurance Policy ID _____ DOB: _____

SSN# _____ Group #_____

Effective Date:_____

Is this visit related to a **WORKMAN'S COMP INJURY**: Yes/No

Date of Injury: _____

Adjuster's Name: _____

Adjuster's phone#:_____

Is this a Motor Vehicle Accident Case? Yes No

Automobile Insurance Carrier:_____

Policy Number:_____ Insurance Carrier's Phone Number:_____

Insurance Carrier's Address:_____

Agent:_____

REFERRING PHYSICIAN: _____ Office #: _____

PRIMARY CARE PHYSICIAN: _____ Office #: _____

PREFERRED PHARMACY: _____

Phone#: _____

Address:_____

_____

Type of appointment : ☐ New Patient ☐ Consultation ☐ Re-established

What is your main reason/primary diagnosis for coming to the clinic today?

History of Present Illness

Condition: ☐ Chronic pain ☐ Non chronic Pain How long have you had the pain?_____

Currently on narcotics ☐ Yes ☐ No If so, what narcotic:_____

Date_____ MR_____ Dr_____

Chronic pain and opioids can produce unwanted symptom. Do you experience any of this

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

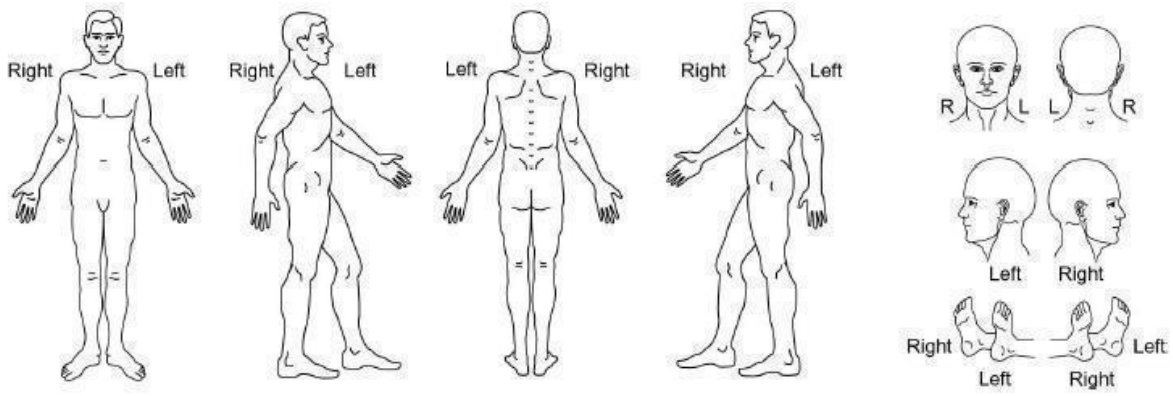
0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

symptoms currently?

☐ Constipation ☐ Headache ☐ Sleep problems ☐ Nausea

Location: Mark the area of injury or discomfort on the chart below



History of Chronic Pain:

Which of the following best describes how the pain began: **Check all that apply.**

___ Accident at home ___Accident at work

___ Work Related ___ Motor vehicle accident

___ After surgery ___ After an illness

___ Just began ___ Came on gradually

o Other: _____

Do you have any of the following with you pain?

- ☐ a. Tingling/numbness in the hands/feet __ Yes __ No
- ☐ b. Weakness in the hands/feet __ Yes __ No
- ☐ c. Pain radiating to arm/hands/forearms __ Yes __ No
- ☐ d. Pain radiating to thigh/buttock/leg/feet __ Yes __ No
- ☐ e. Dragging the foot while walking __ Yes __ No
- ☐ f. Difficulty holding bladder or bowels __ Yes __ No

_____

Does the pain radiate? _____

Chronic narcotic use in the past ☐ Yes □ No

Date_____ MR_____ Dr_____
If so, duration of chronic narcotic use _____

Goal of current therapy _____

Massaging or rubbing __ Coughing __ Strong emotions __ Standing
__ Sudden movement __ Anxiety __ Getting out of bed __ Running
__ Noise __ Heat __ Sitting __ Bright light
__ Cold weather __ Laying down __ walking __ Bending
__ Vibration __ Ice __ Physical Therapy __ Straining
__ Wet climate __ Fatigue __ Reaching __ Lifting
__ Other: _____
Previous Pain Specialist:_____
Current Status: □Stable □Unstable □Improved □Unimproved
Past Testing: □ MRI □ X-ray □ CT □Bone Density Scan Year &
Facility:_____

Does your pain interfere with activity of daily living : □Yes □ No

Check all treatments you have used to treat your current conditions, also where and when you received them:

□ Physical therapy	□ Tens units	_____	_____
□ Traction	□ Pain/stress	_____	_____
□ Chiropractic	management	_____	_____
adjustment	□ Counseling	_____	____
□ Acupuncture	□ Surgery	_____	
□ Epidural injection	_____	_____	
□ Other injection	_____	_____	

Personal History
Have you been arrested or incarcerated? □Yes □ No If so, explain
_____
Do you have a history of illegal drug use? □Yes □ No If so, explain
_____
Do you have a history of depression?□Yes □ No
Do you get angry easily? □Yes □ No

Narcotic Risk Assessment
How often do you have mood swing?
□Never □Seldom □Sometimes □Often □Very often

How often do you smoke cigarettes with in an hour after you wake up?
□Never □Seldom □Sometimes □Often □Very often

How often do you take medications other than the way they are prescribed?
□Never □Seldom □Sometimes □Often □Very often

How often have you used illegal drugs in the past 5 years?
□ Never □ Seldom □ Sometimes □ Often □ Very often

How often , in your life time have you had legal problems or been arrested?
□Never □Seldom □Sometimes □Often □Very often

Date_____ MR_____ Dr_____

Opioid Risk Tools (ORT)

Family history of substance abuse:

□ Alcohol If so, □Male or □Female
□ Illegal Drugs If so, □Male or □Female
□ Prescription drugs If so, □Male or □Female

Personal history of substance abuse

□ Alcohol If so, □Male or □Female
□ Illegal Drugs If so, □Male or □Female
□ Prescription drugs If so, □Male or □Female

Do you have a history of preadolescence sexual abuse?
□Yes □ No

Do you have any of the following psychological diseases:

ADD, OCD, Bipolar or Schizophrenia □Yes □ No
Do you have depression?□Yes □ No

Current medications:

MEDICATION			
Drug	**Dose**	**Time per Day**	**Why**
Example: Norco	*10/325mg*	*1 tab 3 times at day*	*Chronic Pain*

Allergies : Please list below □ No Known Drug Allergies

_____

_____

List all medications (include over-the-counter, herbal and homeopathic) **taken in the past** that was **unsuccessful for you**. Use additional sheet of paper if you need more space to answer pain medication questions.

Date_____ MR_____ Dr_____

Medication _ *ex: Flector patch*	**Dosage/ day** *1 patch every 12 hrs*	**Side effects (if any)** intolerant	**Why d/c, year?** *d/c 2006 - intolerance*

Which of the following conditions are you currently being treated or have been treated for in the past (please check):

□ Heart disease /murmur/angina	□ Anemia	□ Anxiety	□ Cancer
□ High cholesterol	□ Asthma	□ Diabetes	□ Ulcers
□ High Blood pressure	□ Seizures	□ kidney disease	□ Thyroid problems
□ Low blood pressure	□ Stroke	□ Liver disease	
□ Heartburn (reflux)	□ Migraines	□ Hepatitis	
	□ Depression	□ Arthritis	

Please check any past surgeries:

□Appendectomy	□Back Surgery	□Bladder tuck	□Breast lumpectomy
□Atrial fibrillation Ablation	□Eye surgery	□ Bladders Surgery	
	□Carpal tunnel	□Blood transfusion	
□Back fusion	□Endartecdectomy	□Breast implant	
□ Amputation (arms, leg, toes)	□ Cholecystectomy (gallbladder removal)	□ Hip surgery	replacement
		□ Kidney stent	□ Pacemaker
□ Breast reduction	□ Circumcision	□ Kidney surgery	□ Prostate Surgery
□ Breast Augmentation	□ Cosmetic Surgery	□ Laparoscopy	□ BKA
□ Carpal tuner	□ D&C	□ Lumbar Discectomy	□ Testicle Surgery
□ C-section	□ Facial Surgery	□ Lumbar Laminectomy	□ Thyroidectomy
□ CABG	□ Foot surgery	□ Lumbar fusion	□ Vasectomy
□ Cervical fusion	□ Hernia repair	□ Mitral valve	

Family History

Father Living /Deceased age_____ Health Problems

_____

Mother Living /Deceased age_____ Health Problems

_____

Date_____ MR_____ Dr_____
Sister Living /Deceased age_____ Health Problems
_____
Sister Living /Deceased age_____ Health Problems
_____
Brother Living /Deceased age_____ Health Problems
_____
Brother Living /Deceased age_____ Health Problems
_____
_____ Living /Deceased age_____ Health Problems
_____
_____ Living /Deceased age_____ Health Problems
_____

Psycho-social:

Home Type ☐ House ☐ Apartment ☐ Mobil home ☐ Shelter ☐Homeless ☐ Other _____
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Decline to state
Live with: ☐ Spouse/Partner ☐ Kids ☐ Parents ☐ Alone ☐Friends ☐ Pet(s) ☐ Live alone
Employee ☐ Retired ☐ Disabled ☐ Working FT ☐ Working PT ☐ Unemployed
Caffeine ☐ Coffee _____ ☐ Tea ____☐ Soda _____ ☐ Energy drink _____☐ Decaf drinks_____
Smoke ☐ Cigarettes ☐Cigars How many per day_____ , For how long have you been smoking_____
Alcohol use: ☐ Don't drink ☐ Social ☐ Daily: _____per day
In the past year, I have used: ☐ Marijuana ☐ Meth/Speed ☐ Cocaine ☐ Heroin ☐None
I have had problems with: ☐Alcohol abuse ☐ Drug abuse ☐Prescription drug abuse ☐None
Do you required assistant for daily living? ☐ Yes ☐ No

Are you currently experiencing any stressful situations? (circle the one that applies)

- ☐ Martial/relationship stress ☐ Yes ☐ No
- ☐ Stress at work ☐ Yes ☐ No
- ☐ Financial stress ☐ Yes ☐ No
- ☐ Stress with your family ☐ Yes ☐ No
- ☐ Stress with your friends ☐ Yes ☐ No

Date_____ MR_____ Dr_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3

Review of Systems: Please **circle** any symptoms you have so that we can find out more about you.

Fever, chills, sweating, night sweats, unexpected weight changes, fatigue, trouble sleeping, snoring, daytime sleepiness, obstructive sleep apnea, hyperthyroidism, hypothyroidism, excessive thirst, or excessive hunger

Headaches, migraines, vertigo, double vision (diplopia), blurry vision, impaired vision, vision changes, glaucoma, macular degeneration, cataracts, sinus problems, ringing in your ears(tinnitus), nosebleeds, bleeding gums, or sore or lesions in your mouth/throat

Coughing up blood, cough, wheezing or asthma, exposure to tuberculosis, shortness of breath at night, shortness of breath with activity, shortness of breath at rest, COPD

Abdominal pain, blood in the stools, stomach ulcers, constipation, diarrhea, irritable bowel syndrome (IBS), gallstones, hemorrhoids, nausea, vomiting, indigestion, heartburn, GERD, or difficulty swallowing foods, liquids, or medications

Painful urination, bloody urine, kidney stones, hesitancy, dribbling, discolored urine, enlarged prostate, frequent urination

Numbness, tingling, burning, dizziness, lightheaded, fainting or coming close of fainting (passing out), loss of balance, seizures, paralysis

Date_____ MR_____ Dr_____

Arthritis, muscle aches, muscle tenderness, joint pain or redness, swelling, gout, back problems, or open wounds on your legs

Enlarged lymph nodes, blood transfusions, easy bruising, bleeding, anemia, HIV, hepatitis, B-12 deficiency

Rash, skin lesions, itchy skin, change in shape or color of moles

Unusual thoughts, crying, sadness, depression, anxiety, eating disorders, suicide attempts, short term memory loss, long term memory loss, Bipolar disorder, Schizophrenia, dementia, or panic attacks

Would you accept blood products if needed and or have a blood transfusion?_____

Do you need to use any of the following to walk or support yourself since the pain started? __ Cane __ Walker

__ Crutches __ Braces

Date_____ MR_____ Dr_____

Pain Management Agreement

This agreement is between_____(Patient) , FFHC and the prescribers at FFHC.

At FFHC we understand pain is a significant hindrance to a person's quality of life. Our goal is to work with you to help you achieve a better quality of life by reducing the effects of your pain. To achieve this goal we may recommend different medications, diagnostic procedures, physical and occupational therapy, massage, and psychological counseling, as needed.

Narcotic Medication will not be considered a first line therapy in the treatment of chronic pain. This type of medication is given based on the medical findings and treatment plan of our prescribers and not the care you have received in the past. Narcotics have a long history of safety, but there is a great potential for side effects and abuse.

We are therefore obligated to weigh the risks versus benefits of prescribing these medications.

If narcotic medication is determined to be the best treatment option the following guidelines must be agreed by ***Initial all lines and sign the back:***

____ I understand that an improvement in my quality of life is the goal of my treatment.

____ I may be required to consult a psychologist or psychiatrist.
Additional Therapy may be recommended for which I am required to participate.

____ I realize that all narcotic medications have potential side effects. In addition to pain relief, narcotics may produce dependency, addiction, respiratory depression, drowsiness, mood disturbance, and mental clouding. I agree to report any such side effects to the prescriber immediately.

____ Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform any such activity while under the influence of my medication.

____ I will maintain the dosing schedule given by the prescriber. I will not increase the dose without consent of the prescriber. I understand I must make an appointment and come in to discuss any changes before they are made and this will not be done over the phone. If I take my medication in any way other than prescribed, I understand it may not be refilled.

_____ **If I receive a narcotics prescription from any other clinic, doctor, or hospital, I am required to notify FFHC by telephone within one working day. I am also responsible for bringing the hard copy to the office for documentation, and also so that medication can be adjusted/given if applicable.**

____ I agree to have all narcotic prescriptions filled at only one pharmacy and have the pharmacy name and number on file at FFHC.

Date_____ MR_____ Dr_____

____ **I agree narcotics cannot be called in for any reason, that narcotic prescriptions can only be picked up by me, and I may not sell, share or trade my prescriptions with anyone including my family**.

____ I understand narcotic prescriptions will not be replaced if lost, stolen or destroyed for any reason, even if I present a police report.

_____ **I agree to undergo random urine drug screen testing and pill counts. If I am required to do a random pill count I understand that I will be contacted by phone, and it will be my responsibility to provide a telephone number where I can be contacted during regular business hours 8-5 Monday-Friday. If I cannot answer my telephone personally, I am responsible for an answering machine or other method of receiving the telephoned message that day. If I fail to come in for a drug screen or pill count on the day I am called, I may not receive prescriptions from FFHC in the future. ***You are required to bring ALL medication that is prescribed by Pain Management to every Pain Management appointment that you come to.*****

____ I must submit to a urine drug screen at every office visit if requested by the prescriber. I have the option to have the results verified by an independent lab at my own expense.
If requested I understand I will not be allowed to leave the immediate area and will be required to produce a urine

sample in a sufficient quantity to perform a urine drug screen within 30 minutes, failure to do so may cause my medication to be discontinued.

____ If I need to discontinue the use of my medications, I will consult with FFHC and strictly follow their instructions for the safe tapering of my medication. I understand failure to do so may result in severe withdrawal effects and possibly even death. I understand that even with the tapering process there may be some discomfort or withdrawal effects.

____ I understand if I test negative for, or fail to produce a sufficient urine sample to test the presence of my prescribed medication I may not receive a tapering dose or additional prescriptions.

_____ **I agree to not use any illegal drugs or medications prescribed to anyone other than myself**.

_____ **I agree to not drink alcohol while I am taking narcotic medications for pain control.**

____ I must contact FFHC before taking any sedatives, antihistamines, or benzodiazepines. Some examples include but are not limited to: Soma, Xanax, Ativan, Valium and Benadryl., I understand that this facility doesn't not support the use of benzodiazepines and narcotics.

____ By signing this agreement, I give permission to request information and share information about my narcotic prescription history with pharmacies, medical offices, or law enforcement agencies.

____ I understand that all female patients should notify the prescriber if they are pregnant or possibly at risk to become pregnant. I understand that children born while the mother is narcotic

Date_____ MR_____ Dr_____
medication therapy would likely be physically dependent at birth.

_____ I understand that if my family has concerns about my treatment that I may be required to participate in an open discussion with FFHC, my family, and myself regarding my care.

_____ Should this office feel that I might be doing harm to myself or others, I waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication and/or mental state.

____ If I am or ever have been on probation, or arrested for a narcotic related offense, I understand I must disclose this information immediately. I understand that a failure to do so will result in immediate dismissal from FFHC.

____ I understand that it is not the responsibility of FFHC to assist me in finding another healthcare provider in the event I am dismissed for violating this agreement.

This agreement is entered on the _____ day of _____,_____
(Day) (Month) (Year)

My signature below acknowledges my understanding and agreement with the above stated terms.

_____	_____	_____
Patient Name	Date of Birth	Patient Signature

_____	_____
Witness Signature	Witness Signature

Date_____ MR_____ Dr_____

Appointment Cancellations and "No Show" Policy

We expect that our patients will keep their appointments, which are setup with mutual agreement. There are always several patients, who would like to be treated sooner, but have to wait for their turn, as this clinic is very busy.

When a patient does not show up for his/her appointment or does not give adequate cancellation notice, that time slot is wasted, which could have been utilized to take care of other patients, especially for those who would like to get in sooner.
This clinic reserves a right to bill the patients a fee for not showing up or not giving adequate notice for a scheduled appointment

The "No Show" fee is $ 50.00 for any missed Pain Management related appointments (Telemedicine, UDS, Pill Counts, NCS/ANSAR, Pain Physical, Bone Scans, Pain Consultations, etc). That includes being more than 15 minutes late to your appointment (after 15 minutes you will be considered a no show). Also, you are NOT allowed to move/reschedule any UDS appointment once it is booked.

Please note that your insurance company will NOT pay this amount and you will be personally responsible for the fee. We may NOT reschedule your appointment until this fee is paid.

Please be aware that any missed UDS/Testing/Pain Physical must be completed, and NO SHOW fee paid before a Telemedicine visit can be completed for medication. Certainly, we will use discretion while implementing this policy as we realize that true emergencies do occur.

If you are being treated under Workers Compensation insurance, we are also required to notify your Work Comp Adjuster and it may affect your benefits.

I have read the above "Appointment Cancellations and "No Show" Policy". I agree that FFHC Pain Management reserves a right to bill me for not showing up at a scheduled appointment, or for not giving adequate notice of cancellation. I further agree that I may not be rescheduled if I do not pay the "No-Show" charge billed to me.

Patient signature: _____

Date: _____

Date_____ MR_____ Dr_____

AHC Specialty Clinics
Family Fist Healthcare – Pain Management

1999 Prince Ave.
Athens, GA 30606
Ofc. 706-208-9700
Fax: 706-850-8999

11973 Augusta Rd.
Lavonia, GA 30553
Ofc 706-356-8181
Fax 706-356-8081

Authorization to Release Medical Records:

PATIENT INFORMATION:

Name _____ DOB _____

INFORMATION TO BE RELEASED FROM:

Name and address of facility or provider:
_____
_____
_____
Phone and Fax Number:
_____

INFORMATION TO BE SENT TO:

Name and address of designated recipient:

Family Fist Healthcare Pain Management

Fax Number: 706-208-0806 or 706-356-8081

INFORMATION TO BE RELEASED: (check one)

____ the most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
____ All medical records
____ Specific information (please specify):
_____
_____
_____
_____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

____Attorney ____ Insurance __x__ Doctor ____ Personal

Patient Signature: _____ Date: _____

Date_____ MR_____ Dr_____

HIPAA AGREEMENT

Patient Name: _____Date of Birth _____ MR# _____

As a patient I have agreed to let certain individuals participate in discussions and decisions related to my medical care and health information. I hereby authorize Family First Healthcare and their staff to disclose my personal medical information to the following individuals:

1. Name:_____ Relationship: _____
Phone Number: _____
2. Name:_____ Relationship: _____
Phone Number: _____

Terms of Disclosure:

____ Only in my presence should any of my medical information be discussed with the above named people.

____ I authorize Family First Healthcare to discuss my medical information with the above named people in my presence and also by telephone, fax, email, postal mail even when I am not physically present.

I understand that this consent is in effect until I revoke it with a written notice to the practice. I also understand if I have any questions about the privacy of my health information that I can discuss them with the staff at anytime.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Date_____ MR_____ Dr_____

URINE DRUG SCREEN/RANDOM PILL COUNT/INSURANCE PROTOCOL

Patients are responsible for the cost of any urine drug screen, office visit, testing that is not covered by their insurance or if the patient is self pay.

Self pay patients must pay $90.00 for any urine drug screen that is completed in office at the time of service.

Most insurance companies cover the cost of urine drug screens, but there are some that do not. Please check with your insurance company to verify coverage. Family First Healthcare is not responsible for services that are not covered.

Urine drug screens are required to receive any Narcotic medication from the doctor. Urine drug screens are also required every 4 to 6 weeks depending on what insurance you have.

Thank you for your understanding!

Patient Name: _____ Patient Signature: _____

Witness Signature: _____ Date: _____