UNIVERSITY CANCER & BLOOD CENTER

PATIENT INFORMATION FORM

UCBC Physician:_____ Today's date:_____

Name of Patient:_____ Date of Birth:_____ Age:_____

Home Address:_____County:_____

City, State, Zip:_____

Mailing Address (if different):_____

Home Phone: (___)_____ Cell:(___)_____Work:(___)_____

Email Address:_____

Social Security Number:_____ Sex(please circle): Male Female

Race(please circle): African American or Black Asian Hispanic White Other

American Indian or Alaska Native Native Hawaiian or other Pacific Islander

Ethnicity: (please circle): Hispanic or Latino Not Hispanic or Latino

Employer:_____Occupation:_____

Employer Address:_____

Are you retired? Yes☐ No☐ Retirement Date:_____

Emergency Contact

Name:_____ Relation:_____

Address:_____

Home Phone:(___)_____ Cell Phone:(___)_____Work Phone:(___)_____

Miscellaneous

Have you ever served in the military? Yes☐ No☐

Religious preference:_____

Preferred language:_____

Preferred Pharmacy: _____

UNIVERSITY CANCER & BLOOD CENTER

Insurance Information:

I request that payment of authorized Medicare, Medigap, or other insurance benefits be made on my behalf to University Cancer & Blood Center, LLC for services provided.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, my Medigap insurer or any other insurance company about which I have provided billing information, any information needed to determine benefits payable.

_____ _____

Patient Signature Date

INSURANCE INFORMATION

(We will need a copy of your insurance cards, including Rx card. Please list Medicare and Medicaid if you have either.)

Primary Insurance:

Insurance Co:_____

Policy/Group No._____

Policyholder's Name:_____

Policyholder's Date of Birth:_____

Insurance Telephone #:_____

Secondary Insurance:

Insurance Co:_____

Policy/Group No._____

Policyholder's Name:_____

Policyholder's Date or Birth:_____

Insurance Telephone #:_____

Do you have prescription drug coverage? Yes☐ No☐

If yes, through what program?_____

Are you a resident of a skilled nursing facility? Yes☐ No☐

Name of Facility:_____

Facility Address:_____ Telephone: (___)_____

ADDITIONAL INFORMATION NEEDED FOR PROCESSING OF INSURANCE:

Are you still working? Yes☐ No☐

Do you have employer group health coverage? Yes☐ No☐ Number of employees?_____

Is your spouse still working? Yes☐ No☐ Retirement Date:_____

Are you covered through your spouse's insurance? Yes☐ No☐ Number of employees?_____

Do you have a cancer or individual Policy you wish us to file for you? Yes☐ No☐

Does it allow for assignment of benefits? Yes☐ No☐

UNIVERSITY CANCER & BLOOD CENTER

I have agreed to let certain individual(s) participate in discussion and decisions related to my medical care. Therefore, I hereby give permission for University Cancer & Blood Center and Dr._____ and his/her staff to disclose my personal information to the following individual(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Conditions for disclosure (check the item(s) that apply:

☐The practice may disclose my personal health information to the above individual(s) only in my presence.

☐The practice may disclose my personal health information to the above individual(s) in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, email, or regular mail.

☐Other condition of disclosure:_____

I authorize for University Cancer & Blood Center to communicate with me regarding my Private Health Information in the following manner (please check the item(s) that apply):

Leave message on my voicemail/cell phone	Yes☐	No☐
Leave message with a family member	Yes☐	No☐
Leave message with my employer	Yes☐	No☐
Email	Yes☐	No☐

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature:_____ Date:_____

Living Will & Power of Attorney

Do you have a living will?_____

Medical Power of Attorney to make medical decisions on your behalf?_____

Name:_____ Relation:_____

Telephone:_____

(Please provide a copy of this document to our office to keep on file)

Past Medical History, Surgeries, & Hospitalizations

Have you ever been hospitalized or had any surgeries?: Yes☐ No☐

Medical History/Surgery

Medical History/ Surgery	Date:

Hospitalizations (other than surgeries)

When	Where	Reason

Cancer & Blood Disorder History

Have you ever been diagnosed with cancer or a blood disorder? : Yes☐ No☐

Diagnosis	Date	Doctor	Chemotherapy	Radiation	Surgery	Alt.

When was your last colonoscopy?_____

Social & Lifestyle

Tobacco Use	Ever Used?	Frequency	Number of Years	Stopped?

Alcohol Use	Ever Used?	What kind?	Frequency	Stopped?

Other Substance Use	Ever Used?	What kind?	Frequency	Stopped?

Spouse Information

Marital Status: (Please Circle) Single Married Life Partner Divorced Widowed

Health Maintenance

Are you in an assisted- living environment? Yes☐ No☐ If so, which one?_____

Are you currently under hospice care? Yes☐ No☐ If so, which one?_____

****Females only****

When was your last pap smear?_____

When was your last mammogram?_____

Patient doctors	Name	Phone Number	Location
Primary Physician			
Referring Physician			

Family Health History

Immediate Family

Relation	Name	Status	Cancer	Other illness	Notes

Do you have biological children?: Yes☐ No☐

Children

Gender	Name	Status	Cancer	Other illness	Notes

Have any of your blood relatives had cancer (include aunts, uncles, and grandparents)?: Yes☐ No☐

Extended Family

Relation	Name	Status	Cancer	Side

Allergies

Have you ever had an adverse reaction to IV dye used for X-ray studies?_____

Do you have any allergies?: Yes☐ No☐

Allergic to:	Reaction:

UNIVERSITY CANCER & BLOOD CENTER

Patient Name_____ Date of Birth_____

Review of Systems

General	Y	N
Fatigue		
Fever, Chills		
Weight Loss		
Weakness		
Loss of Appetite		
Hot Flashes		
Night Sweats		
Sleep Disturbances		

HEENT	Y	N
Blurred Vision		
Double Vision		
Mouth Sores		
Sore Throat		
Difficulty Swallowing		
Ringing in Ears		

Respiratory	Y	N
Difficulty Breathing		
Wheezing		
Cough		
Hemoptysis		

Cardiovascular	Y	N
Chest pain		
Swelling		

Gastrointestinal	Y	N
Nausea		
Vomiting		
Abdominal Pain		
Diarrhea		
Constipation		
Blood in Stool		
Heartburn		

Genitoruinary	Y	N
Hematuria		
Pain with Urination		
Urgency		

Musculosketal	Y	N
Bone Pain		
Muscle Pain		
Joint Pain		

Integumentary	Y	N
Rash		
Skin Lesions		
Itching		

Neurological	Y	N
Headache		
Neuropathy		
Falling		
Weakness		
Seizures		

Hematologic	Y	N
Bruising		
Bleeding		
Enlarged Lymph Nodes		

Mental Health	Y	N
Anxiety		
Depression		
Suicidal Thoughts		
Insomnia		

UNIVERSITY CANCER & BLOOD CENTER

INFORMED CONSENT

Agreement

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE University Cancer & Blood Center to provide medical care by today's standards. Treatment may include drawing of blood (by venipuncture or finger stick)

I CONSENT to University Cancer & Blood Center use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) including human immunodeficiency virus, psychiatric, drug/alcohol abuse records:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for medical procedures (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purposes and all other uses are known collectively as Treatment, Payment and other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request and PHI including human immunodeficiency, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected diseases to University Cancer & Blood Center when needed for the purposes of TPO.

I also take responsibility for providing enough information order for the office staff to contact me efficiently by mail, telephone, and other forms of communication if necessary. I have been given a copy of University Cancer & Blood Center Practice Privacy Notice. I understand that my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing. I understand that should I choose not to consent to the terms and conditions of University Cancer & Blood Center the practice has the right to and will withhold treatment except where required by law.

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activated without specific and explicit authorization.

Effective: 04/13/2003 Revised: 06/03/2015

Signature

I agree to all provisions therein regarding responsibility for the above mentioned in this Informed Consent Document. I understand that diagnosis or treatment of me by University Cancer & Blood Center may be conditioned upon my consent as evidenced by my signature on this document

Patient Signature_____ Date: _____

FINANCIAL RESPONSIBILITY FORM

Agreement

Financial Responsibility

Please read each line below and sign the page to acknowledge that you have read and understand our office policy regarding the payment of amounts that are the responsibility of the patient.

Financial Responsibility

For patients with no insurance coverage, payment is due at the time of service. As a self paying patient you will receive a discounted rate on your first visit as long as payment is made in full on the date of service. If other arrangements have to be made the office visit will be full charge. We accept cash, checks, and all other major credit cards.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit. All services not paid within 30 days by your insurance company will become your responsibility. It is the patient's responsibility to check their own insurance benefits and coverage.

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

For amounts due after insurance has processed the claim (such as unmet deductibles or non-covered services) we will send you three consecutive statements at 30 day intervals.

You have 15 days after the third statement is sent to pay in full the balance indicated on the statement. If no payment is received, your account may be forwarded for collection process for further action, including additional billing fees.

It is the patient's responsibility to notify us of any changes in insurance, mailing address, or contact information.

Your signature below signifies that you have read each item and understand your responsibility to this office as well as our responsibility to you and your care.

Signature

I acknowledge that I have been made aware of financial assistance opportunities at this clinic

Patient Signature_____ Date: _____

UNIVERSITY CANCER & BLOOD CENTER

MID LEVEL CONSENT FORM

Agreement

University Cancer & Blood Center utilizes a Physician Assistant and Nurse Practitioner in our office for those levels of our practice that have been approved by the Georgia State Board of Medical Examiners.

Signature

I confirm my agreement to being treated by a Physician Assistant or Nurse Practitioner who is under the supervision of the physicians with University Cancer & Blood Center.

Patient Signature_____ Date: _____

UNIVERSITY CANCER & BLOOD CENTER

AUTHORIZATION TO PROVIDE CONTRACTED SERVICES

Agreement

During your care at University Cancer & Blood Center, your physician may prescribe medications. You have the option of receiving these services from the provider of your choice.

Pharmacy Services

University Cancer & Blood Center has the ability to provide you with many prescribed medications through University Cancer & Blood Center Pharmacy, a facility in which the physician owners have an investment interest. These medications will be dispensed to your physician and transferred to you if you desire. A pharmacist is available to provide you with counseling concerning your medications.

In addition to University Cancer & Blood Center Pharmacy, the following pharmacies are available locally and may dispense your medications if desired:

CVS: 1-800-746-7287

Rite-Aid: 1-800-325-3737

Walgreen's: 1-800-289-2273

Or various independent pharmacies

Signature

I indicate that I understand that I have an option of receiving my prescriptions from the provider of my choice.

Patient Signature_____ Date: _____

UNIVERSITY CANCER & BLOOD CENTER

AUTHORIZATION TO PROVIDE COUNSELING SERVICES

Agreement

During your care at University Cancer & Blood Center, your physician may recommend counseling as part of your ongoing cancer care. You have the option of receiving these services from any provider of your choice.

Cancer Counseling Services

University Cancer & Blood Center has the ability to provide you with professional mental health services through the Cancer and Counseling Services. University Cancer & Blood Center employs two oncology social workers, who are available to assist patients and their loved ones in coping with the emotional challenges of diagnosis, treatment, and beyond. Both are licensed mental health professionals who are available to provide counseling services on-site. These services are available as billable to some insurance plans and/or according to a sliding scale fee, for which the physician owners have an investment interest.

In addition to the Cancer Counseling Services, the oncology social work department maintains a list of local and national support services available to assist you in managing the emotional aspects of your diagnosis, treatment, and beyond.

Signature

I understand that I have an option to receive Cancer Counseling Services from the provider of my choice.

Patient Signature_____ Date: _____

UNIVERSITY CANCER & BLOOD CENTER

COMPUTED TOMOGRAPHY (CT) SERVICES

Agreement

During your care at University Cancer & Blood Center, your physician may order a Computed Tomography (CT) Scan. You have the option of receiving these services from the provider of your choice.

Computer Tomography (CT) Services

University Cancer & Blood Center has the ability to provide you with CT services, in which the physician owners have an investment interest. In addition to University Cancer & Blood Center, CT services are available at the following facilities:

Athens Diagnostic Center

706-316-3662

Athens Regional Hospital

706-475-7000

St. Mary's Healthcare System

706-389-3000

The Urology Clinic

706-543-2718

Athena Urology Associates

706-543-6261

Signature

I indicate that I understand that I have an option of receiving my CT scan from the provider of my choice.

Patient Signature_____ Date: _____

UNIVERSITY CANCER & BLOOD CENTER

In order to provide you with the medications which are appropriate and effective, we need to have a list of all prescription and over the counter drugs you are currently taking.

PATIENT MEDICATION LIST

Patient Name		**Date**			
Address:					
City		**State**		**Zip**	
Home Phone:		**Cell:**			
Allergies		**DOB**		**Age**	
Email Address:					
Insurance:		**ID:**			
Pharmacy Name:		**Phone:**			
Primary Physician:		**Phone:**			
Physician:		**Phone:**			
Physician:		**Phone:**			
Physician:		**Phone:**			

CURRENT MEDICATION (RX & OTC)	**STRENGTH**	**DIRECTIONS**	**PHYSICIAN**

Date updated: _____ **Date updated: _____** **Date updated:_____**

Date updated: _____ **Date updated:_____** **Date updated:_____**

Date updated: _____ **Date updated: _____** **Date updated:_____**

Date updated: _____ **Date updated:_____** **Date updated: _____**

Date updated: _____ **Date updated:_____** **Date updated: _____**

Together we will work to ensure everything is done to meet the goals of therapy and to ultimately improve your health.

University Cancer & Blood Center, LLC

3320 Old Jefferson Rd #700 Athens, GA
www.universitycancer.com
(706)353-2990
Attention: Loretta Goodson

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Special Notes:

We do not create or manage a hospital directory.

With your express permission, you may be contacted by Navigating Cancer to participate in the Patient Education program.

We may use and disclose your information for research purposes in certain limited circumstances. We will obtain your written authorization to use your health information for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: 1)the use or disclosure involves no more than a minimal risk to your privacy; 2) the research could not practicably be conducted without the waiver; and 3) the research could not practicably be conducted without access to and use of the health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

UNIVERSITY CANCER & BLOOD CENTER AT ITS FOLLOWING LOCATIONS:

ATHENS-CLARKE COUNTY
FRANKLIN COUNTY
WALTON COUNTY
STEPHENS COUNTY
BARROW COUNTY
PUTNAM COUNTY
NEWTON COUNTY

Patient Signature (NPP receipt acknowledged)

UNIVERSITY CANCER & BLOOD CENTER

Narcotic Medication Treatment Agreement and Consent Form

Patient name _____

Drug Allergy Information: I have ___ no known drug allergies **OR** ___ the drug allergies listed below:

_____

Facility Name: **___** UCBC Medical Oncology ___ UCBC Radiation Oncology

Location: **__** Athens ___Covington __ Eatonton

__ Lavonia __ Monroe __ Toccoa __ Winder

Name of Provider Conducting Informed Consent: _____

At some time during your course of treatment, you may have problems with pain, and your physician may prescribe narcotic drugs (pain-killer drugs) to help manage your pain. Narcotics are a type of drug that should help with your pain and let you be more active in your daily life. It is not expected that your pain will go away completely. However, there are risks linked with these drugs, and you can have side effects. It is important to be honest with your doctor about your pain and the dose you are taking.

There are risks linked to narcotic drugs, which include but are not limited to:

Addiction: There is a chance that you may become addicted to narcotic drugs.
Allergic reaction: All kinds of allergic reactions can happen including a minor reaction such as a rash or a severe reaction such as swelling of your tongue or throat, or a severe allergic reaction which can cause death.
Incomplete pain relief: The dose of narcotic drugs you are on may not take away all of your pain.
Low testosterone levels in men: Narcotic drugs may cause the levels of the hormone testosterone to drop in men. This could change your mood and energy level. You may not want to have sex.
Physical dependence: You may not feel well if your dose is decreased too much or if you suddenly stop taking narcotic drugs. You may have a runny nose, yawning, goose bumps, stomach pain, loose stools, or body aches, or you may feel easily bothered.
Side effects: There are many side effects of narcotic drugs. You may feel itchy, dizzy, or sick to your stomach. You may throw up. You may have trouble having a bowel movement.
Slowed breathing: If you take a dose that is too high, then you could have slowed breathing. You must only take the dose your doctor tells you to take. Do not use other drugs or drink alcohol while taking narcotic drugs. This can cause death.
Slowed reaction time: You may feel sleepy and slow to react. If this happens, then you should not drive, use heavy machines or guns, be at unsafe heights, or be caring for someone else.
Tolerance: Your body could become used to the dose of narcotic drugs that your doctor tells you to take, and you may not get the pain relief you had before.

Other Choices

If you choose not to take narcotic drugs, then you may have other choices to help with pain such as non-steroidal anti-inflammatory drugs (NSAIDS), antidepressants, or seizure drugs. You may wish to see a doctor who specializes in pain management, or you may decide to do nothing and live with the pain that you have. Your doctor will let you know what other choices may be best for you. How well any other treatment works will depend on your specific health problem.

UNIVERSITY CANCER & BLOOD CENTER

There may be local, state, or federal laws that your doctor must follow when prescribing narcotic drugs.

If you take narcotic drugs for **90 days or longer in one year**, you must be observed by your doctor. You will have to come to the office for a visit at least once every 3 months. You may need to have:

- a physical exam,
- lab work to test serum, sweat, urine, or blood,
- the number of pills in your medication bottle counted by someone at the practice, or
- an interview to talk about how you are responding to treatment and new health problems that you may have.

You should not take narcotic drugs if you are pregnant. Narcotic drugs can raise the chance of having a miscarriage or having a baby born with a birth defect. Your baby can also be born addicted to the drug.

Treatment Agreement

By signing the final page of this form, you agree that you understand the rules for taking narcotic drugs. If you do not follow these rules, your doctor shall refer you to a specialist or primary care provider, no longer prescribe pain drugs for you, and/or release you from his or her care.

Drug safety

1. You should lock your drugs in a safe place and keep them away from children. We will also review with you the right way to get rid of any extra drugs.
2. Do not sell, share, or let other people use your drugs. This is a crime and can cause overdoses.
3. You are expected to protect your drugs from loss or theft. Stolen drugs should be reported immediately to the police and to your doctor.

Instructions for taking narcotic drugs

1. You should stop taking all pain drugs that you have used in the past unless your doctor has told you it is safe to keep taking them.
2. Do not stop taking your narcotics suddenly, unless otherwise directed by your doctor.
3. Do not drive after a new pain drug is started or after the dose is increased until you are sure it does not make you sleepy or confused.
4. Do not try to cut or crush your drug unless told to do so; taking cut or crushed narcotics could cause death.
5. You must tell your doctor about all drugs you are taking (including herbal and over the counter drugs) and all health problems you are having. Your drug may not work well or may work differently if you have certain health problems.
6. You must tell your doctor about problems you have with any drugs.

Prescriptions and refills

1. Your narcotic drugs will be prescribed by our office only.
2. You may not ask for pain drugs from any other doctors, other than in emergency rooms.
3. Our office will tell you how many refills you are allowed to get and how often you can get them.
4. Never try to change a prescription. If you do this, then it will be reported to the police.
5. Your prescription may not be replaced if it is lost, stolen, or destroyed by accident.

6. **You will need to let our office know three (3) days ahead of time if you need a refill.** Early refills may not be given. To get refills, you must keep your office appointments. Prescriptions will only be given Monday through Friday during normal business hours.
7. **You should use one pharmacy to obtain all narcotic drugs prescribed by your doctor.**

Appointments

1. You should keep all appointments with doctors, therapists, and counselors. If you miss or cancel appointments often, then your doctor may slowly decrease your dose of narcotic drug until you are no longer taking it.
2. You should bring your drug bottles to each office visit.

Health information

1. Your doctor may need to discuss your treatment with pharmacists and other providers.
2. Legal authorities may ask for your pain treatment records which we will provide if requested.

Consent and Agreement to Treatment

NOTE: If you do not believe that you really understand the risks, likely results, other choices, and possible problems of narcotic drugs, please discuss your concerns with your provider. **Do not sign the form on the signature line below until all your questions have been answered.**

I understand all the facts given to me in this form. I give my consent to UCBC physicians to prescribe narcotic drugs for me**. I confirm that I have not given any false health facts and am not seeking treatment under false pretense. I agree to release my doctor and his/her staff from any liability caused by or due to my misuse of narcotic drug(s), including my failure to comply with this Treatment Agreement.** By my signature below I agree that I have had the chance to ask questions about this form, and that all of my questions have been answered.

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship to Patient (if Responsible Party is not Patient)

_____ _____

Witness Date

Note to Witness: You have been asked to witness this procedure-specific informed consent. By witnessing this form, you are acknowledging that you have asked and the patient has confirmed to you that he or she: has read the whole form, understands the form as it is written, has had his or her questions answered, and chooses to carry on with the doctor's recommendations.

Physician: I confirm with my signature that I have given the patient this three (3) page form. The patient has had the chance to ask questions, all questions have been answered, and the parient has expressed understanding. Thus informed, the patient has asked that I prescribe narcotic drugs for him or her.

_____ _____

Physician Signature Date