NORTHSIDE HOSPITAL

Full Name:_____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German
☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐ yes ☐ no.

Pharmacy Information

Pharmacy Name _____ Phone_____ Fax_____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____ *Email _____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name _____Relationship _____Phone_____

Name _____Relationship _____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance	_____	_____
Name of Policy Holder	_____	_____
Date of Birth of Policy Holder	_____	_____
Policy/Member ID Number	_____	_____
Group/Plan Number	_____	_____
Phone Number	_____	_____
Effective Date of Policy	_____	_____

Patient/Guarantor Signature _____ **Date** _____

Reorder #26985 PP0001 (GCR)
Piedmont Graphics 02/19/16

PATIENT REGISTRATION FORM

NORTHSIDE HOSPITAL

PHYSICIAN PRACTICE

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

English - Spanish

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent annually. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.

_____ I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____
PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____
Note: If phone interpretation used, record interpreter ID #

Reorder #26703 PP0004 (GCR)
Piedmont Graphics Rev. 05/27/16

ANNUAL ACKNOWLEDGEMENT

NORTHSIDE HOSPITAL

English - Spanish

PATIENT'S NAME: _____ DATE OF BIRTH:_____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at a Northside Hospital affiliated medical practice ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician or qualified mid-level provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to the Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice; The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____ _____
Witness Date Time Signature of Patient or Legal representative Date Time

_____ _____
Interpreter (Note: if phone interpretation used, record interpreter ID#) Relationship to patient reason patient can't sign

Reorder #26702 PP0042 (GCR)
Piedmont Graphics 02/20/16

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

ARTHRITIS & TOTAL JOINT SPECIALISTS

Name: _____ DOB: _____
Today's Date: _____ Height: _____ Weight: _____ Work Injury: Y N
Current Occupation: _____
Have you seen another physician regarding this condition? Y N If Yes, List name & dates seen
_____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY OR HAVE APPLIED) ◯ NO PAST MEDICAL HISTORY

CARDIAC
- ◯ A-FIB
- ◯ CORONARY ARTERY DISEASE (CAD)
- ◯ CONGESTIVE HEART FAILURE (CHF)
- ◯ HEART ATTACK (MI)
- ◯ HEART MURMUR
- ◯ HIGH BLOOD PRESSURE
- ◯ HIGH CHOLESTEROL

PULMONARY
- ◯ ASTHMA
- ◯ COPD
- ◯ EMPYHSEMA
- ◯ BRONCHITIS
- ◯ SLEEP APNEA/CPAP
- ◯ BIPAP

ENDOCRINE
- ◯ DIABETES
- ◯ GOUT
- ◯ OBESITY
- ◯ THYROID PROBLEMS

MUSCULOSKELETAL
- ◯ FIBROMYALGIA
- ◯ LUPUS
- ◯ OSTEOARTHRITIS
- ◯ OSTEOPENIA
- ◯ OSTEOPOROSIS
- ◯ RHEUMATOID ARTHRITIS

DERMATOLOGY
- ◯ PSORIASIS

INFECTIOUS DISEASE
- ◯ AIDS/HIV
- ◯ HEPATITIS A
- ◯ HEPATITIS B
- ◯ HEPATITIS C
- ◯ MRSA
- ◯ TUBERCULOSIS (TB)

GASTROINTESTIONAL
- ◯ GERD/ACID REFLUX
- ◯ PEPTIC ULCER DISEASE (GASTRIC ULCERS)
- ◯ HERNIA

CANCER
- ◯ CANCER

TYPE: _____

NEUROLOGICAL
- ◯ STROKE/TIA
- ◯ SEIZURE DISORDER
- ◯ PARKINSON'S DISEASE
- ◯ ALZHEIMER'S DISEASE
- ◯ SPINAL CORD INJURY

GENITOURINIARY
- ◯ KIDNEY DISEASE
- ◯ KIDNEY OR BLADDER STONES

HEMATOLOGY/VASCULAR
- ◯ BLEEDING DISORDERS
- ◯ DVT/BLOOD CLOTS
- ◯ PULMONARY EMBOLISM
- ◯ PERIPHERAL VASCULAR DISEASE
- ◯ SICKLE CELL ANEMIA

REPRODUCTIVE: Are you pregnant? Y N Last Menstrual Period _____ Are you currently breastfeeding Y N
IMMUNIZATION STATUS: Is your immunization status current? Yes No Unknown
METALLIC IMPLANTS: What and where? _____

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY)

CONSTITUTIONAL
- ◯ FATIGUE
- ◯ FEVER
- ◯ NIGHT SWEATS
- ◯ WEIGHT GAIN
- ◯ WEIGHT LOSS

HEENT
- ◯ BLIND/VISUAL IMPAIRED
- ◯ DENTAL PROBLEMS
- ◯ DENTURES
- ◯ GINGIVITIS/GINGIVAL BLEEDING
- ◯ GLASSES OR CONTACTS
- ◯ HEADACHE
- ◯ HEARING AID
- ◯ SINUS PROBLEMS

PULMONARY
- ◯ COUGH
- ◯ SHORTNESS OF BREATH

MUSCULOSKELETAL
- ◯ JOINT PAIN
- ◯ JOINT SWELLING
- ◯ LIMITATION OF ACTIVITY
- ◯ MUSCLE PAIN
- ◯ MUSCLE WEAKNESS
- ◯ RECENT FALLS
- ◯ STIFFNESS
- ◯ UNSTEADY GAIT

SKIN/HEMATOLOGIC/LYMPHATIC
- ◯ ANEMIA
- ◯ CUTS SLOW TO HEAL
- ◯ EASY BRUISE OR BLEED
- ◯ RASHES

GASTROINTESTIONAL
- ◯ BLOOD IN STOOL
- ◯ CONSTIPATION
- ◯ DIARRHEA
- ◯ NAUSEA/VOMITING

NEUROLOGICAL
- ◯ DIZZINESS
- ◯ BURNING/NUMBNESS/TINGLING

WHERE: _____

- ◯ PARALYSIS
- ◯ TREMORS

CARDIAC
- ◯ CHEST PAIN
- ◯ IRREGULAR HEART BEATS
- ◯ SWELLING OF HANDS OR FEET

GENITOURINARY
- ◯ BLOOD IN URINE
- ◯ BURNING/PAINFUL URINATION
- ◯ INCONTINENCE

LIST ALL KNOWN ALLERGIES TO MEDICATIONS ◯ NO MEDICATION ALLERGIES

1. _____ REACTION TYPE: _____
2. _____ REACTION TYPE: _____
3. _____ REACTION TYPE: _____

◯ Latex Allergy ◯ PCN ◯ Adhesive Allergy ◯ Poultry/Egg Allergy Other Allergies: _____

CURRENT MEDICATIONS ◯ NO CURRENT MEDICATIONS

DRUG NAME AND STRENGTH	DOSE	FREQUENCY	PRESCRIBING MD

PAST SURGICAL HISTORY ◯ NO SURGICAL HISTORY

◯ ADENOIDECTOMY
◯ APPENDECTOMY
◯ COLON SURGERY
◯ BREAST SURGERY
◯ HEART BYPASS/CABG
◯ CAROTID SURGERY
◯ CATARACT SURGERY
◯ CESAREAN SECTION (C-Section)
◯ GALLBLADDER REMOVAL
◯ HEART ANGIOPLASTY
◯ HERNIA REPAIR
◯ HYSTERECTOMY
◯ STENT
◯ PACEMAKER
◯ SINUS SURGERY
◯ TONSILLECTOMY
◯ TURP (PROSTATE)
◯ IMPLANTABLE PUMPS/OTHER IMPLANT

PAST ORTHOPAEDIC HISTORY ◯ NO ORTHOPAEDIC HISTORY

◯ ACL RECONSTRUCTION R L
◯ AMPUTATION
◯ ARTHROSCOPY
  ◯ HIP: R L
  ◯ KNEE: R L
  ◯ SHOULDER: R L
◯ BUNIONECTOMY R L
◯ CARPAL TUNNEL SYNDROME R L
◯ CERVICAL SPINE (NECK) SURGERY
◯ FUSION (SPINAL)
◯ FASCITIS
◯ FASCIECTOMY
◯ FRACTURE
◯ INJECTIONS
  ◯ HIP: R L
  ◯ KNEE: R L
  ◯ SHOULDER: R L
  ◯ ELBOW R L
  ◯ WRIST R L
  ◯ HAND R L
  ◯ ANKLE R L
  ◯ FOOT R L
  ◯ SPINE
◯ JOINT FUSION
◯ LUMBAR SPINE SURGERY
◯ NERVE REPAIR
◯ PATELLA DISLOCATION
◯ ROTATOR CUFF REPAIR
◯ SPINAL STIMULATOR
◯ TENDON/LIGAMENT TEARS
◯ THORACIC SPINE SURGERY
◯ TOTAL HIP REPLACEMENT R L
◯ TOTAL KNEE REPLACEMENT R L
  ◯ UNICOMPARTMENT R L
  ◯ PATELLOFEMORAL JOINT R L
◯ TOTAL SHOULDER REPLACEMENT R L
◯ TRIGGER FINGER RELEASE
◯ ULNAR NERVE DECOMPRESSION

ANY ADVERSE REACTIONS TO ANESTHESIA Y N DESCRIBE REACTION: _____

_____

SOCIAL HISTORY

TOBACCO USE ◯ CURRENT PACKS/DAY: _____ ◯ FORMER ◯ NEVER ◯ CHEWING TOBACCO
ALCOHOL USE YES NO IF YES, HOW MUCH PER DAY _____ WHAT TYPE _____
RECREATIONAL DRUGS YES NO IF YES, WHICH DRUGS? _____
HOBBIES, SPORTS, OR EXERCISE: _____

FAMILY HISTORY ◯ NO FAMILY HISTORY

◯ ADOPTED: HISTORY UNKNOWN
◯ ANEMIA
◯ BLEEDING DISORDERS/CLOTTING
◯ CANCER:
  TYPE(S): _____
◯ DIABETES
◯ DVT/BLOOD CLOTS/PULMONARY EMBOLISM
◯ HEART DISEASE
◯ HIGH BLOOD PRESSURE
◯ HIGH CHOLESTEROL
◯ LUPUS
◯ OSTEOARTHRITIS
◯ OSTEOPOROSIS
◯ RHEUMATOID ARTHRITIS
◯ STROKE

EMOTIONAL/SPIRITUAL/CULTURAL HISTORY

MENTAL/EMOTIONAL: ◯ ANXIETY ◯ DEPRESSION ◯ RECENT JOB LOSS ◯ DEATH OF SOMEONE CLOSE TO YOU
◯ CURRENTLY UNDER THE CARE OF A PSYCHIATRIST/PSYCHOLOGIST NAME: _____
DO YOU LIVE ALONE? YES NO
DO YOU HAVE CONCERNS ABOUT YOUR SAFETY, SAFETY OF ANYONE IN YOUR HOME OR THE SECURITY OF YOUR PROPERTY YES NO

COMPLETED BY: _____ DATE/TIME _____ REVIEWED BY: _____ DATE/TIME: _____

Controlled Substances Agreement for Northside Arthritis and Total Joint Specialists

In order to provide the best quality of care, it is critical for you to be compliant with your treatment program. In some cases, narcotics are used as a therapeutic option in the management of pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physicians by establishing guidelines, within the laws, for proper and controlled substance use.

By signing below, you agree to the following:

1. I will only take controlled substances prescribed by the Northside Arthritis and Total Joint Specialists physicians.
2. I will not share, sell or otherwise permit others including spouse of family members to have access to these medications.
3. I agree to take all the scheduled medications exactly as prescribed and agree not to exceed the maximum daily dose on all as needed medications.
4. If a required follow up appointment is missed, I must make and keep another appointment in order for the pain medication to be refilled. Federal Law prevents us from phoning in controlled substances to your pharmacy.
5. Unannounced urine and serum toxicology screens may be requested, and your cooperation is required in order to continue your medication. Presence of unauthorized substances may result in your discharge from our practice.
6. I will not consume excessive amounts of alcohol in conjunction with narcotics, nor will I use, purchase or otherwise obtain any illegal drugs.
7. Medications may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, eaten by your dog, ran over by a car, etc.
8. I agree that attempts to get ANY pain medication from any other source (including other physicians) not specifically approved by the physician will constitute a breach of this agreement and will result in termination of treatment. All requests for refills must be made by contacting your treating physician during regular business hours, and at least five workdays in advance of the anticipated refill. Early refills will not be given.
9. All controlled substances must be obtained at the same pharmacy. The patient's selected pharmacy is:

   Pharmacy: _____ Phone Number: _____
10. The following are strictly forbidden and may result in criminal prosecution – recreational drug use, drug diversion, alteration of scripts, obtaining narcotic drugs from other doctors without notifying our office.

Failure to comply with one or more of the above statements may result in discharge from the Northside Arthritis and Total Joint Specialists practices for three years upon the recommendation from your treatment team after a review of your behavior at the Northside Arthritis and Total Joint Specialists. Thank you for choosing Northside Arthritis and Total Joint Specialists.

_____
Patient's Full Name printed

_____ _____
Patient's Signature Date

_____ _____
Physician's Signature Date