LINCOLN TREE MEDICAL CLINIC OF TULLAHOMA, PLLC
INFORMED CONSENT FOR USE OF OPIOIDS IN THE TREATMENT OF INTRACTABLE PAIN

I, ____________________________________________, the undersigned patient, understand that I am being prescribed opiate medicine, sometimes called Narcotic Analgesics (hereinafter pain medicine), by my physician, Physician Assistant, or advanced practice nurse at Lincoln Tree Medical Clinic for a chronic pain diagnosis. The decision to prescribe these pain medications was made by the physician because my condition is serious or other treatments have not helped my pain.

I am aware about the possible risk and benefits of other types of treatment that do not involve the use of opiates and I have either already unsuccessfully tried those alternatives or am hereby declining the use of those.

I am aware that the use of such pain medication has risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and the possibility that the medicine will not provide complete pain relief.

I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed while using these pain medicines. As a result of this knowledge I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that the interaction of these pain medications with other medications may cause serious complications or other problems. Consequently I will tell the staff about all other medications that I am receiving and all other treatment that I am involved in. I am also aware the combining my pain medication with other medications of failing to restrict the ingestion of my pain medication to the dose and directions stated above can result in serious complications or severe bodily injury, up to and including overdose and death.

I am aware that certain other medicines such as Nalbuphine (Nubain), Pentazocine (Talwin), Buprenorphine an Butorphanol (Stadol), may reverse the action of the pain medication. Taking any of those other medications while I am taking pain medications can result in withdrawal syndrome resulting in symptoms similar to a bad flu. I agree not to take any of the medications listed above.

I am aware that addiction is defined as the persistent compulsive use of a substance known by the user to be physically, psychologically, or socially harmful, I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. Consequently, I agree to provide Lincoln Tree with a complete and honest personal and family drug history.

I am aware that physical dependence is a normal, expected result of using these pain medications for a long period of time. I am aware that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I will have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain, abdominal cramping, diarrhea, aches throughout the body, and a flu-like feeling. I am aware that opiate withdrawal is uncomfortable but, absent other influences, is NOT life threatening.

I am aware that tolerance to my pain medicine means that I may require more medicines to get the same amount of pain relief. I am aware that tolerance to pain medicine is not usually a major problem for most patients with chronic pain; however, it has been observed and may happen to me. If it happens, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opiates may cause the staff at Lincoln Tree to recommend another form of treatment.

(Males) I am aware that chronic opiate use has been associated with low testosterone levels in males. This may affect my mood, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females) If I plan to become pregnant or believe that I have become pregnant while taking my pain medicine, I will immediately call or inform my Obstretrics doctor and Lincoln Tree staff as well. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opiates. I am aware that the use of opiates is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on pain medications and there is always the possibility that my child will have birth defect while I am taking opiates.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all my questions regarding this form and opiate treatment answered to my satisfaction. By signing this form, I thereby voluntarily give my consent for the treatment of my pain with opiate pain medicines.

Patient Signature: ____________________________ Date: ____________________________

Witness Signature: ____________________________ Date: ____________________________
LINCOLN TREE MEDICAL CLINIC OF TULLAHOMA, PLLC
INTRACTABLE PAIN TREATMENT AND MEDICATION CONTRACT

WHEREAS, the "Intractable Pain Treatment Act" codified at T.C.A 63-6-1101 et seq. allows you to decide to have intractable pain treated with controlled substances by your health care provider, nothing in that Act requires that the provider must accept you as a patient or continue to provide controlled substances when conditions exist such that it is no longer in your best medical interests to do so.

THEREFORE, AS EVIDENCED BY MY SIGNATURE AND THE ATTACHED CONSENT AND AUTHORIZATION FOR TREATMENT. I HAVE READ THIS CONTRACT (OR HAD IT READ TO ME) AND UNDERSTAND IT FULLY and agree that compliance with its terms is a prerequisite to the initial and continued receipt of controlled substance medication for the treatment of my intractable pain. I also understand and agree that any violation of this contract may, at the sole discretion of Lincoln Tree Medical Clinic (hereinafter LTMC) result in the termination of my treatment and the dismissal from the practice.

1. LTMC will only provide treatment and medications for chronic pain. I should consult my primary care physician for all other medical issues.
2. I will take my medications at the dose, frequency and exactly as they are prescribed to me. Any adjustments must be approved by an authorized LTMC provider. I understand that LTMC will NOT provide any additional medications if I run out before my next scheduled appointment.
3. I will not drink alcohol and all illegal substances.
4. If I feel tired, or mentally foggy. I will not drive, operate heavy equipment or serve in any capacity related to public safety. I understand that this is likely to occur during dosage adjustments.
5. I will submit to a drug screen upon request of an authorized LTMC provider. LTMC may require a staff member to observe me providing the appropriate specimen. If my drug screen indicates that I am not following the terms of this contract, I may be required to consult with LTMC’s Medical Director regardless of whether my insurance covers such a consultation. I may also be required to submit to an evaluation and/or counseling at a facility specializing in drug addiction/chemical dependence.
6. I will allow my LTMC provider to contact family members, friends, people I work with and other physicians I a seeing in effort to help monitor my progress.
7. I understand that my LTMC provider will be available to prescribe or refill medication ONLY during normal office hours and NOT after hours, on weekends, or on holidays. Healthcare providers at LTMC will not provide me with refills by phone. It is my responsibility to keep my scheduled appointment or to get it rescheduled before I run out of my medications.
8. I will NOT receive medications (opiates, sleeping medications, tranquillizers, stimulants, ETC), from anyone other that LTMC providers without prior approval from an authorized staff member or provider. If I have an emergency that may require additional pain medicine, I will call LTMC provider first if possible. I will inform the doctor at the Emergency room or hospital or at any other facility of this contract with LTMC before requesting or accepting any pain medications from them.
9. I will not share, sell or trade my medication with anyone.
10. I will safeguard my pain medication from loss or theft. If my pain medicines are stolen, I will immediately file a police report. I understand that lost or stolen WILL NOT be replaced under no circumstances.
11. I will keep my medications only for my own use and will not share them with others. I will keep my medications away from reach of children.
12. I authorize my LTMC provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including any states Board of Pharmacy, in the investigation of any possible misuse, prescription forgery, sale, or other diversion of my pain medication. I understand that illegal substance use may be reported to the proper authorities. In the event that any such investigation or incidents requires the disclosure of information from my medical records at LTMC, I hereby agree to waive any applicable privilege or right of privacy or confidentiality with respect to that information necessary to respond to the investigation and inquiry and authorize the release of only such information as is necessary to assist in that investigation.
13. I will inform my LTMC provider of any changes in any other medications I am receiving from other physicians. I will notify all other treating physicians of the existence of this contract.
14. I hereby authorize any pharmacy which has dispensed any medications to me to release to LTMC any information necessary to confirm compliance with this contract.
15. I will have all of my medications prescribed by my LTMC provider filled at one pharmacy unless approved by an authorized LTMC staff member or provider.
16. I am aware that no inappropriate drug behavior, no significant, unmanageable side effects and no conduct inconsistent with the terms of this contract will be tolerated.
17. If it is determined that my pain is being exacerbated and/or out of control, I agree to be hospitalized and to have medications and therapies provided in that controlled environment and in a more clinically controlled fashion. I agree to participate in any medical, psychological or psychiatric assessments recommended by my LTMC healthcare provider.
18. I will inform LTMC by phone atleast 24 hours prior to my appointment if I need to cancel or reschedule.
19. (For women) To the best of my knowledge I am not pregnant at this time. Furthermore, I will do everything I can to avoid getting pregnant while taking the prescribed pain medications unless otherwise approved by and then only in accordance with instructions of my LTMC healthcare provider.
20. I understand pain medications will not be adjusted over the phone and further understand that if my pain changed or increases, I must make an appointment to be seen in the office.
21. I will actively participate in any program designed to improve function including social, physical, and daily or work activities.
22. I will not use illegal or street drugs or another persons prescription medications. If I have an addiction to drugs or alcohol and my LTMC provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include: a 12-step program and securing a sponsor, individual counseling, impatient or outpatient treatment and such other requirements as necessary. If in treatment, I will request that a copy of the programs initial evaluation and treatment recommendations be sent to verify my continuing treatment.

23. I understand that my pain is my pain, not my family’s or spouse’s therefore I am required to be the person to communicate with my healthcare provider at LTMC unless it is not physically possible for me to do so.

24. I understand that LTMC provider may be a Physician Assistant or an Advanced Practice Nurse, but I may schedule an appointment if necessary to see their supervising Physician whenever I feel I need to.

25. I agree that LTMC may terminate this agreement, discontinue my treatment and dismiss me from the practice for any breach of this contract and additionally for any of the following:
   (a) Conduct on my part that evidences moral turpitude such an adverse inference could be drawn that the conduct was a direct or indirect result of the medications and/or treatment received by LTMC and/or
   (b) My arrest for any crime which involves any allegations regarding illegal drug or physical violence; and/or
   (c) Receipt by LTMC from many credible source that I have engaged in conduct that more likely than not indicates abuse of the substances prescribed by LTMC or which reflects adversely on the treatment I have received from LTMC.
   (d) I am aware that LTMC does Random pill counts and that at any time I may be required to being all my medication that is prescribed to me into the office to be counted by an authorized LTMC staff member or may be ask to take the medication to a pharmacy locally within the county in which I am at. The pill count must be done within the time frame (reasonable) that is told to me when called by LTMC authorized staff member. Failure to comply with this requirement may result in termination from the clinic.
   (e) I also am aware that if I am out of town when called for a pill count that I may be required to contact the office back from a land line for verification of where I am. If this is not done within a reasonable time frame I may be terminated from the clinic.
   (f) If I do not comply with these terms set forth within this contract and LTMC healthcare provider has reasonable cause or reason to believe that continuation of my care may be a risk of his Medical License that he will terminate my care immediately and I will no longer receive any pain medication from LTMC. I will be required to follow up with my Primary Care Physician for additional refills or referrals.

I have read (or had it read to me), understand and agree to comply with this contract. I have been given the opportunity to have all my questions addressed regarding all of the terms of this contract.

Patients Name (Printed): ____________________________ Date: __________________

Patients Signature: ____________________________ DOB: __________________

Primary Care Physician: ____________________________ Phone: __________________

Name of Pharmacy: ____________________________ Phone: __________________
LINCOLN TREE MEDICAL CLINIC OF TULLAHOMA, PLLC
MEDICAL HISTORY/ QUESTIONNAIRE

PATIENT NAME: ______________________ DOB: ____________

1. LIST ALL SURGERIES YOU HAVE HAD. PLEASE BE AS COMPLETE AS POSSIBLE INCLUDING BOTH THE DOCTORS NAME, DATE, AND HOSPITAL:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. LIST ALL MEDICATIONS:
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__________________________________________________________________
__________________________________________________________________

3. LIST ALL ALLERGIES:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

4. HAVE YOU OR ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH CANCER _____________ IF YES PLEASE LIST TYPE/WHO
__________________________________________________________________
__________________________________________________________________

5. PLEASE LIST ALL FAMILY HISTORY MEDICAL PROBLEMS:
___ HEART DISEASE ___ DIABETES ___ STROKE ___ TUBERCULOSIS
___ HIGH BLOOD PRESSURE ___ ALCOHOL ABUSE ___ DRUG ABUSE

6. DO YOU SMOKE _____ IF YES HOW MANY PACKS A DAY _____

7. HOW LONG HAVE YOU BEEN SMOKING _____

8. ARE YOU EMPLOYED _____ DISABLED _____ UNEMPLOYED_____
9. IF YOU ARE ON DISABILITY WAS IT FOR ___MENTAL DISABILITY OR ___PHYSICAL DIABILITY

10. PLEASE LIST ALL CURRENT MEDICAL CONDITIONS:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
I HAVE:

____ TAKEN A HIPAA NOTICE OF PRIVACY PRACTICES FOR
MY RECORDS

____ BEEN OFFERED A HIPAA NOTICE OF PRIVACY
PRACTICES FOR MY RECORDS BUT HAVE DECLINED TO
TAKE IT WITH ME.
DR ROTH IS EMPLOYED AS THE MEDICAL DIRECTOR OF THE SLEEP LABORATORIES AT UNITED REGIONAL MEDICAL CENTER IN MANCHESTER TENNESSEE AND AT SOUTHERN TENNESSEE MEDICAL CENTER IN WINCHESTER TENNESSEE.

CONSEQUENTLY, PERSUANT TO THE TENNESSEE CODE ANNOTATED, SECTION63-6-502, YOU ARE HEREBY NOTIFIED OF THAT POTENTIAL CONFLICT OF INTERST AND ARE FREE TO REQUEST A REFERRAL TO AN ALTERNATE SLEEP LABORATORY FOR PERFORMANCE OF WHATEVER MEDICALLY NECESSARY SLEEP STUDY THAT MAY BE RECOMMENDED.

PLEASE CHECK WITH THE REFERRAL CLERK SHOULD YOU WISH TO HAVE AN ALTERNATE REFERRAL.

I HAVE READ AND UNDERSTAND MY OPTIONS FOR A SLEEP STUDY IF ONE IS REQUESTED BY THE PHYSICIANS AT LTMC

_________________________  ___________________  _____________
SIGNATURE                 PRINTED NAME               DATE
Patient Authorization for Use and Disclosure of Protected Health Information

By signing this release, I authorize Lincoln Tree Medical Clinic of Tullahoma PLLC
Dr James Roth, Lisa Diaz-Barriga FNP, Allen E Tate PA-C
To use and/or disclose or to receive certain protected health information (HPI) about me to/ from :

Located at

This permits Lincoln Tree Medical Clinic of Tullahoma, PLLC to use and/or disclose the following individually identified health information:

My Entire Medical record _____________

With the exception of the item(s) checked below:

_______ Substance Abuse, If any

_______ Psychological or Psychiatric Conditions

_______ AIDS/HIV, If any

_______ Other:

The purpose of this request is “at the request of the individual “unless otherwise stated. The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from the date of signature below.

The practice will not receive payment or other remuneration from third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Lincoln Tree Medical Clinic of Tullahoma, PLLC. In fact, I have the right to refuse to sign. When my information is used or disclosed pursuant to this authorization, it may be subject to re disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at : 1600 McArthur Street, Manchester, Tennessee 37355

Signed By:

Signature of Pt or Legal Guardian ____________________________ Relationship to Pt ____________________________

Patient Name ____________________________ Date of Birth ____________________________

Print Patient Name ____________________________ Date ____________________________