Marla Golden, D.O.
Integrative Pain Management
12443 San Jose Boulevard, Suite 201
Jacksonville, FL 32223
Phone: (904) 260-1070
Fax: (904) 260-1170

Today's Date: _____

Dear New Patient:

Welcome to the practice! I am looking forward to seeing you and working with you to manage your pain. There are some policies and procedures that I would like to make known to you; these have been instituted for your protection, safety, and well-being. Please read this letter carefully and be sure you are willing to comply with the policies, procedures, and rules of our practice. First, I would like to be able to review your medical records including any copies of reports of diagnostic studies, x-rays (CAT scans, MRI's, ultrasounds and any pertinent lab work) as well as actual films, if at all possible, prior to your first visit. I realize this is difficult, but it is very helpful.

You are required to have a primary care physician to manage your basic medical care. I will be providing your pain management only. It is my preference to send office visit notes to you primary care physician to keep them informed of your progress with respect to your pain management. Many patients have other embers of their Pain Management Team. These may include psychiatrists, a physical therapist, as well as other types of practitioners in addition to your primary care physician. You have the right to decide who is kept informed. We can discuss this further at your first visit. It would be extremely helpful if you would bring to your first visit the names and numbers of all treating physicians or health care professionals that are part of your chronic pain management team.

Urine drug monitoring is done randomly on every patient as a policy of Integrative Pain Management. The purpose is to monitor medication changes, disconcerting signs or symptoms associated with medications, and to determine how mediations are being taken.

To stay in compliance with insurance and DEA regulations, you will be responsible to bring all of your prescription bottles with you to each appointment. Your office visits will be schedule every 28 days and your prescriptions will be written for 30 days. A pill count will be conducted at each office visit. No prescriptions will be issued at the first visit.

I am hopeful that we will enjoy an open and honest physician/ patient relationship since I believe this is critical to the success of your overall pain management program.

The treatment plan at Integrative Pain Medicine features the Neuroplastic Transformation program and is based on the core concept of neuroplasticity and the body's ability to change in response to the input it receives. You will move through phases of care designed to restore function and allow you to return to a pleasurable life. The emphasis of treatment options changes as you move through the phases.

If you have any questions or concerns prior to your first appointment, please feel free to call the office. My staff will be happy to answer questions of any kind. If you have any further concerns, I will be happy to discuss them at your initial visit. Once again, I am happy to welcome you to the practice and look forward to meeting you.

Please bring your insurance card(s), a picture ID, medications, medications list, and any applicable copayment.

We look forward to being of service to you.

Sincerely,

Marla Golden, D.O., FACEP
Director, Integrative Pain Management
Electronically reviewed and signed

Your appointment has been schedule for _____ at _____.
Please arrive with completed paperwork 30 minutes prior to your appointment time.
Please be sure to call the office with your insurance information prior to your first appointment.

Thank you!

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CONTROLLED SUBSTANCE POLICY INFORMATION CONSENT

As part of your treatment with Dr. Golden, you may need a prescription to control your pain. These mediations can include narcotics (painkillers) and sedative/hypnotic (anti-anxiety/sleeping pills). These medications are called controlled substances. They are monitored closely by the Drug Enforcement Agency in Washington, D.C.

Therefore, we have a strict set of rules you must follow while under our care using these medications.

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

_____ I agree to bring in all of my medications to every visit. This includes all pill bottles, pills, daily dose packs, and pill containers of any kind. This policy is to ensure your safety when prescribing medications.

_____ I agree to never share or sell any of my medications.

_____ I understand and agree that I am fully responsible for all my medications

_____ I agree never to obtain additional pain medications from any other Healthcare Provider including my Primary Care Provider unless I get approval from Dr. Golden.

_____ I agree to fill my prescriptions with only one pharmacy.

_____ I agree never to increase my dose prior to discussing this with Dr. Golden.

_____ I understand that there exists a risk of developing an addictive behavior with many of these drugs. Although this behavior is a rare occurrence, it still can happen.

CONTROLLED SUBSTANCE POLICY INFORMATION CONSENT
Page 2

_____ I understand that if my medications are stolen, I will report to my local police department within 24 hours and prior to Dr. Golden prescribing another refill. I agree to obtain a stolen/missing item report from the police. More than one lost or stolen medication occurrence is considered irresponsible behavior and will result in discharge from our practice.

_____ I understand that Integrative Pain Management will conduct random quarterly drug screens on all patients. Drug screens may also be conducted with medication changes, disconcerting signs or symptoms associated with medications, or at Dr. Golden's discretion.

_____ I understand and agree that due to the seriousness of these medications, Dr. Golden will NEVER be able to phone in any refills. All prescriptions will be given out at office visits only. NO EXCEPTIONS.

_____ I understand that I waive all rights to HIPPA regulations if found in violation of any controlled substance act with respect to illicit or prescription drug use, abuse or diversion.

_____ I understand that any and all violations of the controlled substance acts with respect to illicit or prescription drug use, abuse or diversion will be handed over to law enforcement to take the necessary and proper steps to investigate.

_____ I have read and understand the above policy and by signing this form, I agree to follow these rules.

_____ I understand that any breech in any rule are grounds to be discharged from the practice formally by a written letter; as well as, personally contacting your primary care physician or referring physician.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Pharmacy: _____ Phone: _____

Name: _____ Date: _____

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CONSENT FOR CHRONIC OPIOID THERAPY

Dr. _____ is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of _____.

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain 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 possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:

_____
_____
_____

I will tell my doctor about all other medicines and treatments that I am receiving.

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. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. 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 certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other

doctors that I am taking an opioid as my pain medicine and can't take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chances of becoming addicted to my pain medicine are very 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. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

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

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increase doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

Males Only:
I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, 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 Only:
If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the

mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I confirm that I have read, or have had read to me, and understand all the above information in this consent form. I understand my responsibilities in receiving this treatment and agree to follow the guidelines in this consent. I have been given the opportunity to have all of my questions regarding this treatment answered to my satisfaction. I am of sound mind, under no undue influence and am competent to make this decision and do so of my own free will. I have no further questions. I voluntarily consent for the treatment of my pain with opioid pain medicines.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I hereby certify that I have explained the nature, purpose, benefits, risks, and alternatives to the proposed opioid treatment, have offered to answer any questions and have fully answered such questions. I have explained in layman terms the substantial risk, hazard, complications and consequences, which are or may be associated with the opioid treatment. I believe that the patient fully understands what I have explained and has consented to undergo the proposed treatment. The patient appears to be of sound mind, under no undue influence and competent to make this decision

Physician Signature: _____ Date: _____

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Patient's Last Name:	**Patient's First Name:**	**Middle Initial:**	**Patient's SSN:**	**Date of Birth:**

Patient's Street Address:	**City:**	**State:**	**Zip Code:**

Sex:	**Patient Marital Status:**	**Home Phone:**	**Other Phone:**
☐ **Male** ☐ **Female**	☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**		

Patient or Parent's Employer:	**Occupation (Indicate if student):**	**Business Phone and Extension:**

Name of person financially responsible for this account (if other than patient):	**Relationship to Patient:**	**Responsible Party's DOB:**	**Responsible Party SSN:**

Responsible Party's Address (if other than patient):	**City and State:**	**Zip Code:**	**Phone:**

Primary Care Physicians:	**Street Address, City, State, Zip:**	**Phone:**