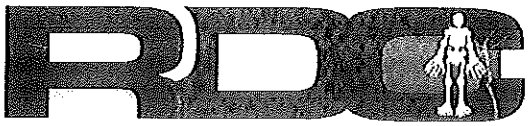

Rheumatic Disease Clinic

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Rheumatic Disease Clinic of Houston** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

This notice of Privacy Practices provided by **Rheumatic Disease Clinic of Houston** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rheumatic Disease Clinic of Houston reserves the right to revise its Notice of Private Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Rheumatic Disease Clinic of Houston.**

With this consent, **Rheumatic Disease Clinic of Houston** may call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO. For example, appointment reminders, lab tests results, insurance items and any call pertaining to my clinical care.

With this consent, **Rheumatic Disease Clinic of Houston** may mail to my house or other alternative location any items that assist the practice in carrying out TPO, such as appointment cards or patient statements. I have the right to request that **Rheumatic Disease Clinic of Houston** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to allow **Rheumatic Disease Clinic of Houston** to use my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If, I do not sign this consent, or later revoke it, **Rheumatic Disease Clinic of Houston** may decline to provide treatment to me.

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Signature:_____ Date:_____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

Patient's Name: _____
(Last) (First) (Middle)

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ **Cell Phone:** ( ) _____

Work Phone: ( ) _____

Email Address_____home___ work___
If work, is it ok to email you? _____

Sex: _____ Marital Status: _____ Date of Birth: ___/___/___ **Social Security #:** _____-_____-_____

Patient's Employer: _____

Address: _____
(City) (State) (Zip)

Spouse's Name: _____

Spouse's Employer: _____

Address: _____
(City) (State) (Zip)

Referred By: _____**If physician please provide referring physician's phone number and address:** _____

NOTIFY IN CASE OF EMERGENCY:

Name: _____ Phone: ( ) _____ Relationship: _____

INSURANCE:

1st Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____/_____/_____

ID#: _____ Group#: _____

2nd Insurance Company: _____

Policy Holder's Name: _____Date of Birth: _____/_____/_____

ID#: _____ Group#: _____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

PHARMACY:_____

NAME_____

PHONE/ADDRESS:_____

1ST Insurance Company:_____

Policy Holder's Name:_____Date of Birth:____/____/____

ID#:_____Group#:_____

2nd Insurance Company:_____

Policy Holder's Name:_____Date of Birth:____/____/____

ID#:_____Group#:_____

3rd Insurance Company:_____

Policy Holder's Name:_____Date of Birth:____/____/____

ID#:_____Group#:_____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

ACKNOWLEDGEMENT OF RESEARCH STUDY:

Rheumatic Disease Clinic often participates in research studies. Would you be interested in being part of a study if you qualify? _____

Signature_____Date:_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

This office does not accept responsibility for collecting your insurance proceeds or for the negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I authorize payment of Medicare and/or other insurance benefits to be made directly to Rheumatic Disease Clinic on my behalf for any and all services rendered. I also authorize Rheumatic Disease Clinic to release my protected health information for treatment and billing purposes.

Signature: _____ Date: _____

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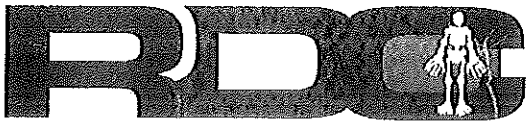

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Signature:_____ Date:_____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

Rheumatic Disease Clinic

Patient's Name: _____
(Last) (First) (Middle)

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ **Cell Phone:** ( ) _____

Work Phone: ( ) _____

Email Address_____home___ work___
If work, is it ok to email you? _____

Sex: _____ Marital Status: _____ Date of Birth: ___/___/___ **Social Security #:** _____-_____-_____

Patient's Employer: _____

Address: _____
(City) (State) (Zip)

Spouse's Name: _____

Spouse's Employer: _____

Address: _____
(City) (State) (Zip)

Referred By: _____**If physician please provide referring physician's phone number and address:** _____

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ID#: _____ Group#: _____

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Policy Holder's Name: _____Date of Birth: _____/_____/_____

ID#: _____ Group#: _____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

Rheumatic Disease Clinic

DATE_____

PHARMACY:_____

NAME_____

PHONE/ADDRESS:_____

1ST Insurance Company:_____

Policy Holder's Name:_____Date of Birth:____/_____/____

ID#:_____Group#:_____

2nd Insurance Company:_____

Policy Holder's Name:_____Date of Birth:_____/____/____

ID#:_____Group#:_____

3rd Insurance Company:_____

Policy Holder's Name:_____Date of Birth:_____/_____/____

ID#:_____Group#:_____

RHEUMATIC DISEASE CLINIC OF HOUSTON

PATIENT INFORMATION

DATE_____

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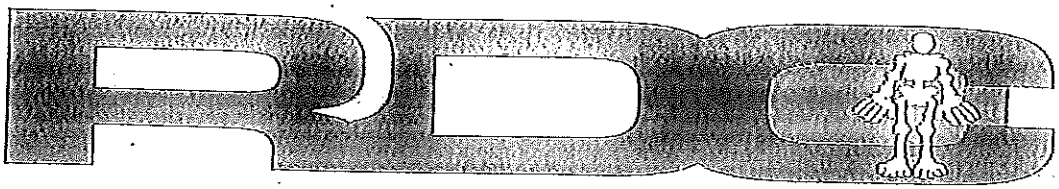


Rheumatic Disease Clinic

Authorization For Release of Medical Records to Rheumatic Disease Clinic

Patient: _____

Date of Birth: _____

Thereby Authorize and request:

_____

_____

_____

_____

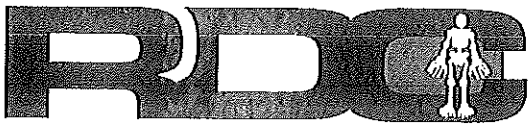
To Release the complete medical records in your possession, concerning my illness and/or treatment to Rheumatic Disease Clinic at the address or fax number listed below.

Thank you,

Patient's Signature: _____

Date: _____

4825 Almeda Rd., Houston, TX 77004 ☎ (713)521-7865 office ☎ (713)521-7856 fax



Rheumatic Disease Clinic

PHYSICIAN OWNERSHIP DISCLOSURE FORM

To: New Patients on Date of First Visit with Samuel B. Pegram, MD. / RDCH

During the course of your physician/patient relationship with Dr. Pegram, Dr. Pegram may refer you to Rheumatic Disease Clinic of Houston (RDCH), including its Infusion Suite, Radiology Suite, Laboratory, Durable Medical Equipment Services and products such as braces, compression stockings, diabetic shoes, ointments, etc., and Pharmacy (the "Facility"). The address of the Facility is 4825 Almeda Rd., Houston, TX 77004.

In connection with any referral to the Facility, you are hereby advised that Samuel B. Pegram, MD has an investment interest in the Facility and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you at the time of Dr. Pegram's contact with you as a patient and will also be provided to you at the time of referral, if any, to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician, the physician's staff, or the Facility if you choose to use a different facility.

Should Dr. Pegram at any time refer you to the Facility and you prefer to use a different health care provider, you will be advised of alternative health care providers and your right to choose one of these alternative health care providers.

_____

Patient name (please print)

_____

Patient signature

_____

Date

Rheumatic Disease Clinic

NOTICE OF PRIVACY PRACTICES

During your treatment at Rheumatic Disease Clinic, our caregivers may gather information about your medical history and current health. This Notice of Privacy Practices explains how that information may be used and shared with others. It also explains your privacy rights regarding this information.

Rheumatic Disease Clinic is required by law to abide by the terms of this Notice, to make sure that information that identifies you is kept private, and to give you this Notice of our legal duties and practices with respect to medical information about you. We are also required to notify you in the event there is a breach of your health information.

Uses and Disclosures of your Health Information

Rheumatic Disease Clinic may use health information to carry out treatment, payment and health care operations. Treatment is the provision, coordination or management of health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers.

Payment includes the activities necessary to obtain reimbursement for the provision of health care. For example, we may need to give your health plan information about treatment you received at Rheumatic Disease Clinic so your health plan will pay us or reimburse you for the treatment.

Health care operations include the activities necessary for Rheumatic Disease Clinic to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

We may use or disclose your health information:

When required by federal, state, or local law.

To support public health activities by reporting as required or authorized by state or federal law. These reports may include the reporting of exposure to a communicable disease or risk of spreading a disease or condition.

To cooperate with law enforcement officials for certain law enforcement purposes as directed by a court order, warrant, criminal subpoena, or other lawful process.

To report abuse or neglect.

To support health oversight activities that are authorized by law, such as administrative or criminal investigations, inspections, licensure or disciplinary actions and other similar activities necessary for appropriate oversight of government benefit programs or functions.

When required by a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as required by law.

When necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, as consistent with applicable law and standards.

For judicial or administrative proceedings, in response to a valid court order, administrative order, a grand jury subpoena, or with your written consent.

For research purposes, with your written authorization or as permitted by law.

To business associates to perform functions on Rheumatic Disease Clinic's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.

We may disclose your health information to a family member, other relatives, or a close friend or any other person you identify if the information relates to that person's involvement in your health care if you consent to such a disclosure. If you are unable to agree or object to the use or disclosure, we may disclose such information as necessary if we determine that it is in your best interest.

Continued on other side ⟹

Patient Rights

Inspect and obtain a copy of your health information. You have a right to inspect and obtain a copy of your health information that is used to make decisions about your care for as long as Rheumatic Disease Clinic maintains the information. You may request an electronic copy of this health information that we maintain electronically. This right does not apply to certain health information, including information compiled in reasonable anticipation of or for litigation. Requests for access to health information should be made in writing to the Rheumatic Disease Clinic Administrator. You may also ask us to provide a copy of this health information to another person. In that case, your written request must be signed by you, must clearly identify the person to whom you want us to send the copy of your health information, and must state where the copy is to be sent. If access is denied, you will be provided with a written explanation that sets forth the basis for the denial, a description of how you may review those rights and a description of how you may complain.

Request an amendment. You have the right to request that Rheumatic Disease Clinic amend your health information if it is incorrect or incomplete. Requests for amendment of information should be made in writing to Rheumatic Disease Clinic Administrator, and you must provide a reason that supports your request to have the information changed. Rheumatic Disease Clinic may deny your request for an amendment if the request is not in writing and submitted to the Administrator. In addition, we may deny your request if you ask us to amend information that: (a) was not created by Rheumatic Disease Clinic (unless the person or entity that created the information is no longer available to make the amendment); (b) is not part of the medical information kept by Rheumatic Disease Clinic; (c) is not part of the information you would be permitted to inspect and copy; or (d) is accurate and complete.

Request communications by alternative means or at alternative locations. You have the right to request confidential communications by alternative means or at alternative locations. For example, you may request that we communicate with you only by mail. We will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled. You must request confidential communications in writing.

Request a general restriction. A general restriction is one that restricts or limits our use or disclosure of your health information. To request a general restriction, you must identify in this request: (i) what particular information you would like to limit, (ii) whether you want to limit use, disclosure, or both, and (iii) to whom you want the limits to apply. We will consider your request but are not required to agree. We have the right to terminate the restriction if: (i) you agree orally or in writing to terminate the restriction, or (ii) if we inform you of the termination, which becomes effective only for your health information created or received after we inform you of the termination.

Request a plan restriction. A plan restriction is one that meets the following three conditions: (a) it is to restrict disclosure of your health information to a health plan for purposes of payment or health care operations; (b) the health information relates solely to a health care item or service for which you, or someone on your behalf, has paid us in full; and (c) the disclosure is not otherwise required by law. If you wish to request a plan restriction, you must do so separately for each service visit, and must make your request at Rheumatic Disease Clinic **before** your visit.

Obtain a copy of this Notice. To obtain a paper copy of this notice, contact the Administrator at Rheumatic Disease Clinic.

Complaints. If you believe your privacy rights have been violated you may complain to the MinuteClinic Privacy Office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints should be submitted in writing. You will not be penalized in any way for filing a complaint.

Rheumatic Disease Clinic Duties

Rheumatic Disease Clinic reserves the right to change its privacy practices and this Notice, and to apply the changes to any health information received or maintained by Rheumatic Disease Clinic prior to the date of the changes. If the terms of this Notice are changed, a revised version will be available upon request and will be posted in a clear and prominent location. You may access the notice by visiting our website at: www.RDCH.org

Rheumatic Disease Clinic

4825 ALMEDA RD

HOUSTON, TEXAS 77004

RHEUMATOLOGY PATIENT HISTORY FORM

Date: _____/_____/_____ .

Birthplace:_____

NAME: _____ Birthdate: _____/_____/_____

Last First M. I.

Home Phone:_____

Age:_____ Sex: ☐ F ☐ M

Cell Phone:_____

Address: _____

Marital status: ☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

Who Referred You to our clinic? _____

Your pharmacy name and phone number: _____

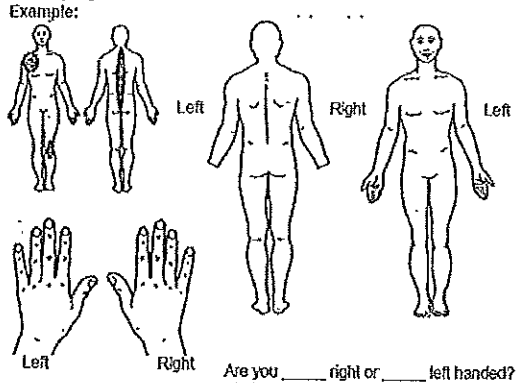
Name and phone number of your primary care physician: _____

Name and phone number of orthopedic physician. _____

Describe briefly your present symptoms: _____

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



Are you ____ right or ____ left handed?
(Which hand do you sign your name with?)

When did your symptoms start? _____

What diagnosis have you been given, if any?

Please list the names of other practitioners you have seen for this problem:

Physician initials _____

Previous treatment for this problem (include physical therapy, surgery, and injections; medications to be listed later): _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative	→	Name/relationship
Arthritis (type unknown)	❑	❑	→	_____
Osteoarthritis	❑	❑	→	_____
Rheumatoid arthritis	❑	❑	→	_____
Gout	❑	❑	→	_____
Lupus or "SLE"	❑	❑	→	_____
Ankylosing spondylitis	❑	❑	→	_____
Childhood arthritis	❑	❑	→	_____
Sjogren's syndrome	❑	❑	→	_____
Osteoporosis	❑	❑	→	_____
Psoriasis/psoriatic arthritis	❑	❑	→	_____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	
❑ I have a pacemaker		

Other significant illnesses (please list): _____

Previous Operations

Type	*Year*	*Reason*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Physician initials _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications, such as aspirin, vitamins, glucosamine, laxatives, calcium, etc.

Name of drug	Dose (include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PERSONAL HISTORY

What is your highest educational level? ❑ High school ❑ Some college courses ❑ College graduate ❑ Advanced degree

What is your current or past occupation? _____

Are you currently working? : ❑ Yes ❑ No If yes, hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability? _____

What date did this disability begin? _____

How much exercise do you get each week? _____ What kind of exercise? _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children:

Physician initials _____

SYSTEMS REVIEW

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Morning stiffness
  Lasting how long ____ Minutes
  ____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

List joints affected in the last 6 months

_____
_____
_____
_____

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye

MOUTH
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑Loss of taste
- ❑ Dryness
- ❑ Recent increase in tooth cavities

NOSE
- ❑ Nosebleeds
- ❑ Loss of smell

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw while chewing

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART AND LUNGS
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain relieved by food
- ❑ Vomiting of blood/"coffee grounds"
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

KIDNEY/URINE/BLADDER
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Frequent urination
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

BLOOD
- ❑ Anemia
- ❑ Bleeding tendency

SKIN
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling in hands/feet
- ❑ Memory loss
- ❑ Muscle weakness

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

For women only:
Age when periods began: _____
Number of pregnancies: _____
Number of miscarriages: _____
Have you reached menopause?
❑ No ❑ Yes If yes, at what age: ____
Date of last Pap smear: _____
Date of last mammogram: _____

If you are still having periods:
Are they regular? ❑ Yes ❑ No
How many days apart? _____

Physician initials _____

□ Dr.Pegram □ Dr.Peer □ Dr. Manning

CONTROLLED SUBSTANCE PRESCRIBING AGREEMENT

Patient Name(Print)_____

Terms of Agreement:

1. This and all controlled substances are to be prescribed only by the physician named above. Any attempt to obtain controlled substances from any other physician outside this practice will be grounds for immediate termination from the practice.
2. The agreed upon prescription will be given only to the patient named above (unless patient authorizes a designated surrogate with a valid state I.D to pick up prescription)
3. The amount of the medication dispensed over a given time period will be determined by the physician in order to achieve adequate pain control. Only the stated amount of medication will be prescribed until the end of that time period. The amount will be recorded in you chart.
4. Whenever possible alternative treatment regiments such as non-narcotic analgesia, physical therapy, injections and surgical intervention should be pursued in order to limit the use of and duration of the controlled substance therapy.
5. **I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during the following office hours: Prescription refills must be requested by Thursday at 3:00pm. Refills will only be given Monday through Thursday from 9am until 5pm. Refills on Friday will be given until 1pm. Except for holidays until 11am. No refill on weekends.**
6. Patients needing to pick up **TRIPLICATE PRESCRIPTIONS** agree that they will contact the office **NO** less than 24 hours prior to arriving to pick up the prescription or it will **NOT** be provided. **There are no exceptions.**
7. A PHARMACY MUST BE SPECIFIED BY YOU and only this pharmacy will be permitted to be used for your controlled substances (unless physician is informed ahead of time before refill is given). You must comply with this as requested or risk termination of care .
8. Random **URINE DRUG SCREENS** may be conducted to confirm medication adherence and to evaluate for diversion of controlled substances.
9. **PRESCRIPTION HISTORIES** from the TX Board of Pharmacy may be reviewed periodically. In addition **RANDOM PILL COUNTS** my be conducted, if felt to be necessary by the physician.
10. Any alterations to the written prescripton OR ANY DISCREPANCIES IN PILL COUNTS OR PRESCRIPTION HISTORIES may result in termination from the practice as well as notification of local law authorities.
11. **I will not use any illegal controlled substances, including marijuana, cocaine etc.** Any breach of the agreement shall result in immediate termination from the practice.
12. **I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.**

*****I have read the above and agree to the terms of the agreements for use of the controlled substances as stated. I understand that any breach of the contract shall possibly result in immediate termination from the practice of Rheumatic Disease Clinic of Houston. I also understand that controlled substances may become habit forming and carry risk of abuse, addiction, and overdose. Furthermore, I have been advised not to operate a motor vehicle or machinery while under the influence of any controlled substances due to the potential risk of harm to self and others.**

Patient Signature	Physician Signature	Date