**Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent for Charles C. Carter, MD DPh, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and/or healthcare operations (TPO).

With this consent, Charles C. Carter, MD DPh, PLLC, 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. I also consent to allow Charles C. Carter MD DPh, PLLC, to mail and/or email, to my home, or other alternative location, any items that assist the practice in carrying out TPO.

 I have the right to request that Charles C. Carter, MD DPh, PLLC, restrict how it uses or discloses my PHI to carry out TPO. However, this practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**Insurance and Financial Authorization**

I hereby authorize the release of medical information to insurance carriers necessary to process claims and hereby assign all payments directly to the providers at Charles C. Carter, MD DPh, PLLC. I understand that I am personally responsible for charges not covered by this assignment. I also understand and agree with the financial policies stated in the Carter Clinic pamphlet.

**Opiate Agreement**

I agree to the following rules and procedures of management of my chronic pain condition. Failure to follow these rules will result in constriction of the boundaries of management, increasingly frequent office visits, consultations, or expulsion from this program, at the discretion of Charles C. Carter, MD DPh, PLLC.

1. I will obtain controlled medications only from Charles C. Carter, MD DPh, PLLC, unless I am hospitalized, in which case the hospital doctor will decide which pain medications are appropriate.
2. I will not request the doctor to phone in the pain prescriptions, nor ask the pharmacist to phone or fax the doctor for this type of medication. Prescriptions will be issued only during office visits, never by telephone, in order to determine whether my medication should be continued.
3. I will consent to a blood or urine drug test anytime asked, so that the physician may verify the absence of illegal drugs and to determine if adverse hormonal or chemical changes are occurring due to the treatment. I agree to abstain from all illegal drugs including marijuana. I agree to all consultations and referrals that the physician recommends.
4. I will fill my prescription at only the drugstore which I will designate.
5. I grant authority to the physician, without further written consent, to obtain and exchange medical information with other doctors, past or future, dentists, hospitals, emergency rooms, nursing homes, or other healthcare providers, pharmacists, clinics, and/or either healthcare authorities, including but not limited to, the DEA and OBN, the Board of Medical Licensure, or other authorities.
6. I will keep my appointment with the physician to assess my progress. The physician will be looking for adverse effects, lack of improvement in function, and addiction behaviors or lack thereof.
7. I understand that it is my responsibility to protect my supply of medications against theft of loss. I will not expect much sympathy from the doctor if I lose my medications for whatever reasons. I agree to file a police report about loss or theft of dangerous medications and obtain a copy of the report for my doctor’s records. The doctor is under no obligation to replace my stolen medication, but I am under obligation to tell the doctor if it is stolen or lost.
8. Should I become addicted, or in the opinion of the physician, I display drug abuse behaviors, the physician may discontinue my medications by tapering, or provide me with Clonidine or other medication for alleviation of withdrawal symptoms, which are flu-like, and/or referring me to an addiction specialist, or drug abuse counselor(s).
9. I understand that my progress will be measured not only in terms of alleviation of pain, without significant side effects, with the result being improved daily activities and improved quality of life. If the medications do not result in improving my activities, functional capacity, and/or quality of life, the physician reserves the right to taper and stop my medications.
10. I will keep the doctor informed about my legal situation, including traffic stops, arrests of any kind, marital problems, and other legal difficulties while I am under treatment. I will volunteer the information at my next appointment so that the physician can determine if my medications are contributing to my legal problems.

**Acknowledgment of Notice of Carter Clinic Practices**

I acknowledge I have received the Carter Clinic Pamphlet containing the Notice of Privacy Practices and the Clinic’s policies, rules, terms, and conditions.

**I have read the above agreement along with the Carter Clinic Pamphlet, or they have been read to me. I understand and approve the clinic policies and this agreement. All my questions were answered in a language that I understood. I agree to follow the rules and the terms of this agreement knowing I could be dismissed from care if I do not comply.**

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***Patients Printed Name Date***

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***Patient/Guardian Signature***

*If patient is unable to sign, responsible party signature and relationship.*

Agreement is in effect unless revoked in writing by patient.

***For office Use Only*** In lieu of patient signature, I,

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Employee of Charles C. Carter, MD DPh, PLLC, state that the patient has been given our current notice of rules, policies, terms, and conditions. Please initial \_\_\_ if patient refused to sign.

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*Employee’s Signature Date*