



Douglas E. Hemler, M.D. *Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine*
 Kyle C. Morgan, D.O. *Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine*
 Kirk Prochnio, P.A.-C.

SPINE AND SPORT

Please Print!!

Patient Legal Name (First MI Last)		Patient SS#		Patient Date of Birth	
Nickname	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Address		Home Phone#		Work Phone#	
City, State, Zip		Other #		Cell #	
Employer	Occupation	Race	Ethnicity	Preferred language	

Collection of race, ethnicity, and language data would allow stratification of quality measures in physician practices to create awareness of differential practice patterns or response among patient populations and accordingly identify opportunities for quality improvement. The ARRA provision for "meaningful use" of EHRs applies to enabling the exchange of health information and reporting on clinical quality measures to CMS, medical boards, private plans, and others.

I. Please list the family members or other persons (doctor, attorney, nurse case manager, adjuster, etc), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

II. Please list the family members or significant others, if any, whom we may inform your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone _____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

() _____

* **I am fully aware that a cell phone is not a secure and private line.**

** **I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.**

VI. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?

YES _____ NO _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Insurance Information – Financial Responsibility Statement: *Please present insurance cards to be copied.*

	Primary Insurance	Secondary Insurance
Insurance Name		
Mailing Address for Claims		
Insurance Phone #		
Insured's Name		
Insured Relationship to Patient	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Group Name/Group #		
Policy #		
Is preauthorization required for office visits, diagnostic tests, hospitalization and/or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Nonsurgical Orthopedics, Interventional Spine Procedures, Sports Medicine, Electrodiagnosis, Occupational Medicine, Pain Management, Rehabilitation

2801 Youngfield Street
 Suite 150
 Golden. CO 80401

303-238-4277
 Fax: 303-238-4977
 www.starcolorado.com

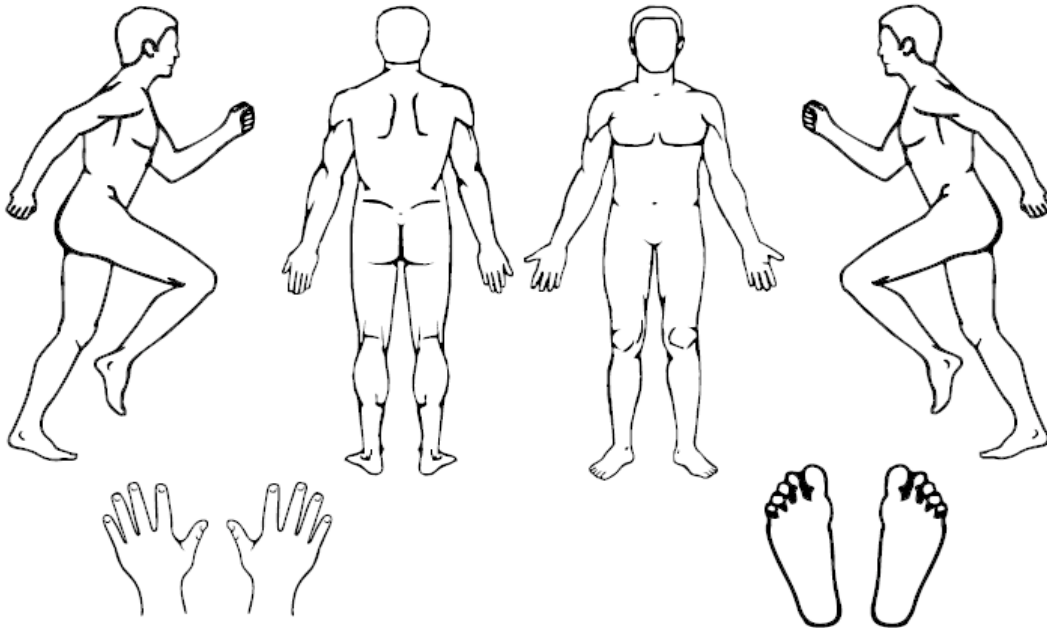
Patient Name: _____

ALLERGIES

<i>Medication Name</i>	<i>Type of Reaction</i>
Do you have environmental Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please list:
Do you have food Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No Please list:
Do you have a known allergy to Latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please place an "X" on the lines below indicating the level of your pain over the last two weeks:

- a.) What is your least pain? 0 -----5-----10(worst pain imaginable)
- B.) What is your worst pain? 0 -----5-----10(worst pain imaginable)
- a.) What is your pain today? 0 -----5-----10(worst pain imaginable)



Mark
worst
best times of day for your pain:

the
and

WORST <input type="checkbox"/> First Awakening <input type="checkbox"/> Morning <input type="checkbox"/> Mid-day	<input type="checkbox"/> Evening <input type="checkbox"/> Nighttime <input type="checkbox"/> With Activity <input type="checkbox"/> With Rest	BEST <input type="checkbox"/> First Awakening <input type="checkbox"/> Morning <input type="checkbox"/> Mid-day	<input type="checkbox"/> Evening <input type="checkbox"/> Nighttime <input type="checkbox"/> With Activity <input type="checkbox"/> With Rest
--	--	---	--

Please describe any problems with the following since the pain/injury:

Bowels:	Urination:	Sleep
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DIAGNOSTIC STUDIES

Please indicate if you have undergone any of the following studies and the results if you know them.

<i>Test</i>	<i>When</i>	<i>Where</i>	<i>Results</i>
<input type="checkbox"/> Plain X-Rays			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Myelogram			
<input type="checkbox"/> MRI			
<input type="checkbox"/> Discography			
<input type="checkbox"/> Bone Scan			
<input type="checkbox"/> EMG			
<input type="checkbox"/> Other			

Patient Name: _____

PAST MEDICAL HISTORY *Have you ever been DIAGNOSED with any of the following problems?*

	Yes	No	Year	Comment
Have you ever had similar or identical symptoms?	<input type="checkbox"/>	<input type="checkbox"/>		If yes, please explain:
CANCER (please list type):	<input type="checkbox"/>	<input type="checkbox"/>		
Cardiovascular Do you have a pacemaker High/Elevated Cholesterol High Blood Pressure Other Heart Problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Respiratory Asthma COPD Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Gastrointestinal Hepatitis Reflux Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Kidney Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>		
Mental and Emotional Depression (requiring treatment) Anxiety (requiring treatment)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
Hematologic/Immunity Anemia HIV/AIDS Mononucleosis Bleeding after surgery Blood transfusion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Other Not Listed Above Problem:	<input type="checkbox"/>	<input type="checkbox"/>		

PAST HOSPITALIZATIONS AND SURGERIES

Have you ever been hospitalized for a medical problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list below:			
Year	Reason for Admission	Date	Physician

OTHER TREATMENTS

Please check list the other treatments you have had for this pain/injury.		
<input type="checkbox"/> Hot Packs <input type="checkbox"/> Ice <input type="checkbox"/> Ultrasound <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> Massage <input type="checkbox"/> TENS unit for home use <input type="checkbox"/> Traction <input type="checkbox"/> Back School	<input type="checkbox"/> Local (trigger point) injections <input type="checkbox"/> Epidural Injections <input type="checkbox"/> Facet block <input type="checkbox"/> Nerve Root Block <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Osteopathic Manipulation <input type="checkbox"/> Body Mechanic Training	<input type="checkbox"/> Anti-inflammatory Medication <input type="checkbox"/> Narcotic Pain Medication <input type="checkbox"/> Muscle Relaxant Medications <input type="checkbox"/> Braces/supports <input type="checkbox"/> Aerobic Exercises <input type="checkbox"/> Home Exercise Program <input type="checkbox"/> Strengthening Exercises
Are you happy with the medical treatment you have received up to this point in time? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please explain:

Patient Name: _____

REVIEW OF SYSTEMS Do you CURRENTLY have any of the following problems?

	Yes	No	Comment
General Health Problems: Fever Chills Night Sweats Weight Loss/Gain > 10 lbs/1 month Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	What is your current Height: _____ Weight: _____
Head/Neck Problems: New Headache Vision/Eye problems Earache, loss of hearing Chronic sinus infections	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Cardiovascular Problems: Blacking out/Fainting Bluish discoloration of lips/fingernails Chest pain Irregular heartbeat/palpitations Swelling of ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Respiratory Problems: Frequent non-productive cough Frequent productive cough Shortness of breath Short of breath climbing 1 flight of stairs Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Gastrointestinal Problems: Difficulty swallowing/food sticking in throat Abdominal pain Constipation Diarrhea Heartburn Nausea Vomiting Blood in stools Black, tar-like stools	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Neurologic Problems: Numbness Tingling Seizures Weakness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Urologic Problems: Blood in urine Difficulty starting urine stream Burning Leaking of urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Mental and Emotional Problems: Depression (requiring treatment) Anxiety (requiring treatment)	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Endocrine Problems: Feel cold all the time Feel hot when others do not Increased appetite Diabetes Thyroid deficiency Thyroid excess	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hematologic Problems: Swollen Lymph Nodes Bruising easily Bleeding into joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Skin Problems: Itching Rash	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

Patient Name: _____

LIFESTYLE AND ENVIRONMENTAL

Have you ever smoked? Do you smoke now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (indicate amount per day):
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (indicate amount per week):
Do you use any recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments (indicate frequency):

OCCUPATIONAL HISTORY

Where do you work?	How long have you worked there?	Job Title:
How Physically Demanding is your job?	<input type="checkbox"/> Very Heavy (frequently lifting > 100 pounds) <input type="checkbox"/> Heavy (frequently lifting > 60 pounds) <input type="checkbox"/> Moderate (frequently lifting > 30 pounds) <input type="checkbox"/> Light (frequently lifting < 30 pounds) <input type="checkbox"/> Sedentary (essentially no lifting)	
Please rate how emotionally stressful your job is: (0 = none, 10 = severe)	Comments:	
Are you currently working?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last day worked:
How satisfied are you with your job?	<input type="checkbox"/> Very satisfied <input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied <input type="checkbox"/> "It is the worst job I've ever had"
Work status today (please describe):		

FAMILY HISTORY *Please mark all that apply:*

					Maternal		Paternal	
	Mother	Father	Brother	Sister	Grandma	Grandpa	Grandma	Grandpa
Specific Anesthesia problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (please list type) under check mark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:								
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory:								
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic:								
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic								
Bleeding/clotting problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature (Must be a parent or guardian for children 17 and under)

Date

For Office Use Only:



Douglas E. Hemler, M.D. Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine

Yusuke Wakeshima, M.D. Board Certified PM&R

Kirk Prochnio, PA-C

SPINE AND SPORT

I, (PLEASE PRINT) _____, have been informed and clearly understand the following issues regarding the treatment of pain with opioids (i.e., morphine or morphine-like drugs).

1. Approximately monthly visits are required for management of the medications and refills of the pain medication prescribed will be given on a monthly basis. Failure to perform monthly visits would result in slow tapering and ultimate discontinuation of all opioid medications. The physician may require more frequent visits.
2. Medications used will be prescribed by a single physician. The individual must be aware that "doctor shopping" is an unacceptable behavior. The same physician will be managing the possible side effects during use of opioids. This physician will be the only one to decide when and how the patient is to increase the opioid dosage. If the physician decides to discontinue the use of opioids, the physician will follow him/her through this tapering off period and the patient will agree to recommendations made by the physician.
3. The use of the medication is not to completely eliminate pain. Rather, the medication is used to significantly reduce pain so that the individual will be able to perform many activities of daily living as well as social activities. It is hoped that the use of these medications will improve the quality of life but it is unexpected that pain relief will be complete.
4. The individual must report significant side effects to each of the opioid medications. For example: over-sedation, nausea, vomiting, constipation, confusion, euphoria (high feelings), and dysphoria (down feelings). Other side effects which may be related to narcotic use also include dizziness; sweating; respiratory depression; gastrointestinal upset; quick, sudden jerky movements of the arms or legs; headaches; weakness; tremor; seizure; dreams; musculature rigidity; transient hallucinations; disorientation; visual disturbances; insomnia; dry mouth; diarrhea; stomach cramps; taste alteration; flushing of the face; chills; increased or decreased heart rate; increased or decreased blood pressure; difficulty with urination; itching; skin rashes; and swelling of the skin.
5. It is clearly understood that the use of this medication may result in physical dependence. This condition is common to many drugs including steroids, blood pressure medications, anti-anxiety medications, and anti-seizure medications, as well as opioids. Physical addiction poses no problem to the individual or to the doctor as long as the individual avoids abrupt discontinuation of the drug. Medication can be safely discontinued after two to three weeks of slow tapering.
6. Psychological addiction should also be understood as a possible risk to the use of opioid medications. This has been shown to be an infrequent occurrence in patients who have been diagnosed with an organic disease causing chronic pain. Psychological addiction is recognized when the individual abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or "doctor shopping," when the drug is quickly escalated without correlation with pain relief, and when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the individual exhibits such behavior, the drug will be tapered; such a patient is not a candidate for continued opioid usage.
7. Tolerance is also a condition which can occur with the use of opioid medications. It is defined as a need for a higher opioid dose to maintain the same pain control. Usually, tolerance to sedation, euphoria, nausea and vomiting occurs more commonly than tolerance to pain relief. This condition may be controlled by switching to a different opioid medication. Tolerance can also be managed by adding a second different drug to the opioid management. If tolerance to opioids becomes unmanageable, the opioid will be tapered and discontinued.

8. If the individual develops drowsiness, sedation or dizziness, he or she may not drive motor vehicles or operate machinery that can jeopardize his/her or other people's lives.
9. Use of this medication is only designed for the individual that the medication is prescribed to. The medication should never be distributed to others. Once the maintenance opioid dose has been achieved, the individual will be given a monthly supply and no exceptions will be made.
10. During the use of the opioid medications, the individual is responsible for contacting the physician if at any time excessive drowsiness or other major side effects develop. The phone number to contact would be (303) 238-4277.
11. The individual is informed that he/she may not stop taking the opioid medications abruptly. If this happens, withdrawal symptoms usually occur 24-48 hours after the last dose. The individual may begin to experience yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, "goose flesh," abdominal cramps and diarrhea. The withdrawal symptom is self-limited but could be life-threatening. It may last a few days. In order to avoid the withdrawal symptoms, the patient is informed that he/she is to contact the office seven days prior to needing a new prescription.
12. The individual is informed that he/she may not take other drugs such as tranquilizers, sedatives or antihistamines without first consulting with his/her physician. The individual may not use alcohol. The combination of the above drugs, alcohol and opioids may produce profound sedation, respiratory depression and blood pressure drop.
13. During the use of these medications, the individual should follow the physician's directions and not increase the opioid dose on his/her own. Drug overdose can cause severe sedation and respiratory depression and possibly death.
14. The medications should be taken as prescribed. Medications should be taken whole and are not to be broken, chewed, or crushed. Possible risk would be rapid absorption of the medication, causing anxiety.
15. It should be understood by the individual that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. It should be known that children born when the mother is on opioid maintenance therapy will likely be physically dependent at birth.
16. If there is any evidence of drug hoarding, acquisition of drugs from other physicians, uncontrolled dose escalation or other aberrant behavior, this would be followed by tapering and discontinuation of opioid maintenance therapy.
17. The individual may be required, at their own expense, to have periodic drug and/or alcohol testing.

Signature of patient: _____

By signing this document, I am indicating that I have fully read and understood this document.

Witnessed by: _____

Signature of physician: _____

Date: _____



Douglas E. Hemler, M.D. Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine

Kyle C. Morgan, D.O. Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine

Kirk Prochnio, P.A.-C.

Patient name: _____ Date of birth: _____

From: _____

I. My Authorization

Please disclose the following health care information:

All my health information maintained at your practice (Circle “include” or “exclude” for each of the following)

- Including My health information related to drug abuse
- Including My health information related to alcohol abuse
- Including My health information related to HIV/AIDS
- Including My health information related to psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Sports and Orthopedic Rehabilitation, PLLC
2801 Youngfield, Suite 150
Golden, CO 80401 PHONE 303-238-4277 FAX 303-238-4977

Reason for this authorization: _____

This authorization ends: _____

II. My Rights

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may revoke this authorization by writing a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date



Douglas E. Hemler, M.D. Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine

Kyle C. Morgan, D.O. Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine

Kirk Prochnio, P.A.-C.

NAME: _____

DOB: _____

Please read and sign all of the following:

Assignment of Benefits

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred to collection, I agree to pay reasonable collection expenses including attorney's fees. In the event that I am entitled to health insurance or other benefits relating to my medical condition and available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. I understand that there will be a \$25 charge for cancelling an appointment with less than 24 hours notice or failing to attend an appointment with no notice. Further, I understand that there will be a charge for telephone consultations. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I further permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Signature

Date

HIPAA - Notice of Privacy Notices

I acknowledge that I will be given a copy of the Notice of Privacy Practices for Douglas Hemler M.D. and KyleMorgan, D.O., if I request a copy.

Signature

Date

FMLA/Disability Form Completion

I am aware that an appointment is required for all forms to be completed. This includes but is not limited to FMLA and Disability Paperwork. There is also a two week turn-around time for all forms so please plan ahead.

Patient Signature

Date

Check in time / arrival time policy

Our office requires that all new patients arrive thirty minutes early and all established patients arrive fifteen minutes early. We ask our patients to arrive prior to their scheduled appointment time because we do have multiple patients scheduled with multiple providers. This early arrival time allows our staff adequate time to process all the necessary paperwork in a timely fashion in order to help keep all of our providers on schedule, and to honor your scheduled appointment. In the event that our providers are running late, we will make every attempt to notify you prior to your arrival. If you are not able to arrive early as our policy states, you may be asked to reschedule.

Patient Signature

Date



Douglas E. Hemler, M.D. *Board Certified PM&R, Pain Medicine, Electrodiagnostic Medicine*

Kyle C. Morgan, D.O. *Board Eligible PM&R, Pain Medicine, Electrodiagnostic Medicine*

Kirk Prochnio, P.A.-C.

Prescription Refill Policy

Please initial each section

_____ Prescription refills are handled Monday thru Thursday from 9am to 4pm. Prescriptions will not be refilled after hours or on the weekends.

_____ Requests for prescription refills require an appointment with a provider. Please be aware of when you are coming to the end of the supply of your medications, emergent appointments cannot always be accommodated.

_____ No walk-in appointments for prescription refills will be accommodated.

_____ Prescription refills will only be approved for 3 months or 1 month for controlled substances, after which an appointment with a provider is required.

_____ If you need to change the type of medication, an appointment with a provider is required. In emergent situations you may go to an Urgent Care or ER, after contacting our office.

_____ If you lose or misuse a prescription, we will not authorize a refill without an appointment.

_____ No refills authorizations will be called in or faxed to the pharmacy.

_____ We are not responsible for getting your mail in prescriptions to your mail in pharmacy. This is the patient's responsibility.

Patient Signature

Date