**DCS Family Health Clinic Consent & Authorization to Treat**

**A. Consent for Examination and Treatment:**

I hereby authorize the providers and employees of DCS Family Health to perform and administer the tests and diagnostic procedures that are deemed necessary, including, but not limited to, imaging examinations, blood tests and other laboratory procedures as may be recurred by the clinic or may be ordered by my physician(s) or persons working under the general and/or special instructions of my physician(s)

1.  I understand and agree that this consent covers all authorized persons, including but not limited to residents, nurse practitioners, physicians' assistants. , specialists, consultants and independently contracted physicians who are called upon by the physician in charge to carry out the diagnostic procedures and medical or surgical treatment.

2.  I hereby authorize DCS Family Health Clinic to retain or dispose of any specimens or tissue, should there be such remaining from any test or procedure.

3.  I hereby authorize and give consent for DCS Family Health Clinic employees to take photographs, images Or videotapes of such diagnostic, surgical or treatment procedures of patients as may be required by DCS Family Health Clinic or as may be ordered by a provider . With the exception of radiologic images, DCS Family Health Clinic is not obligated and may not retain videotapes or photographs for any period of time, if the medical record contains a record of the surgical, diagnostic or treatment procedure.

4.  I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the outcome of any tests, procedures or treatment

5.  I further acknowledge and agree that DCS Family Clinic may use cameras or other devices for patient monitoring.

 **B. Authorization for Release of information:**

Authorization is hereby granted to release to all insurance companies, their successors, assigns, parties with whom they may have contracted or others acting on their behalf that are involved with payment for any clinic charges all information that the insurance companies request and deem necessary for payment/reimbursement and potential quality of care issues This authorization is valid until revoked in writing by me.

**C. Medicare Patient's Certification and Authorization to Release Information and Payment Request:**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim I request that payment of authorized benefits be made on my behalf.

D. **Assignment of Insurance Benefits:**

I hereby authorize all insurance company(ies) to pay all clinic and medical benefits now due and to become due and payable to me under my policy(ies), including Major Medical Benefits, direct to DCS Family Health Clinic and all independently contracted provider for life, unless revoked in writing by me.

**E.  Acceptance of Financial Responsibility:**

**I agree that** in consideration of the services and supplies that have been or will be furnished to the patient, I am hereby obligated to pay all charges made for or on the account of the patient according to the standard rates (in effect at the time the services **and supplies** are **delivered)** established by DCS Family Health Clinic I understand that 1 am responsible **for all charges, or portions thereof, not covered by** insurance or other sources Patient refunds will be distributed only after balances at DCS Family Health Clinic are paid.

**F. Relationship between Clinic and Provider:**

I understand that some, but not all, providers furnishing services to the patient, including, but not limited to Emergency **Department** physicians, radiologists, and pathologists, are independent contractors and are not employees or agents of the Clinic. The patient is under the care and **supervision of his/her attending providers and it is the responsibility of** the Clinic and its nursing staff to carry out the instructions of such physicians. It is **the responsibility of the patient's provider to obtain the** patient's informed consent, when required; for medical treatment, special diagnostic or therapeutic procedures, or Clinic services rendered for the patient under the special instructions of the provider.

**Notice of Privacy Practices:**

I acknowledge I have received a copy or reviewed DCS Family Health Clinic’s HIPPA Notice of Privacy Practices and that 1 agree to the above terms of this consent and authorization to treat form.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                      Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian's Signature** (If patient is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of the patient** (If greater than 18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Controlled Substance and Opioid Agreement Informed Consent Form**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) have read this agreement carefully and do agree to the following conditions concerning my **narcotic prescription.**

**PLEASE READ THE CONTENTS OF THE FOLLOWTNG AGREEMENT CAREFULLY.**

I acknowledge that this is an agreement and explanation of issues related to the treatment of disorders through the use of controlled substances including opioids (such as morphine, Vicodin, Soma, Xanax) between this clinic and me, the patient, **should it be determined by the provider that I am a candidate for this type of therapy**. Failure to comply with any of these conditions may result in discharge from this clinic.  \_\_\_\_\_\_\_\_ (pt. initials)

**Side Effects and risks:**

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you now and may be discussed later. Side effects and/or risks include, but are not limited to, allergic reactions, sedation, sleepiness, respiratory depression (slowed breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, decreased libido, dependence, tolerance, addiction, or death.

**Caution:**

Opioid medications may cause drowsiness. Alcoholic beverages should not be taken concurrently. You should not drive, operate machinery or make important decisions whilst experiencing side effects of these medications.

The **following conditions must be met and agreed-upon as long as the patient is receiving treatment at this clinic. Non-compliance with any of these conditions may result in discharge from the practice.**

 This clinic will be the only source for controlled medications. The patient may not obtain these medications from another physician unless explicitly approved by one of the physicians at this clinic.

 The patient understands that the treatment goal is to improve quality of life and function. These parameters are assessed periodically.

Medications must be taken only as instructed and prescribed by one of the providers at this clinic. **The patient will use only one pharmacy. Please furnish the pharmacy number now.**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_           Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

L**ost or stolen prescriptions will NOT be replaced. It** is the patient's responsibility to insure that prescriptions are filled correctly at the pharmacy. If the patient realizes that a medication is lost, stolen or misplaced, a police report must be filed and documented at this clinic.

The patient should keep all appointments in order to insure efficiency of treatment and monitoring. Prescriptions will not be called in, given after-hours or during the weekend. All prescription issues should be discussed at the time of the office appointment. The clinic has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.

The patient may be asked for random urine and/or serum drug screening test at any time. The patient may also be asked for a random pill count. Failure to comply with these requirements will result in immediate discharge from the practice.

**The patient may not share, sell or otherwise divert controlled substances including opioids.**

I, the undersigned, attest that 1 have read the above agreement, understand, and agree to all of the requirements. I understand that non-compliance may result in discharge from the clinic.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                      Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian's Signature** (If patient is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of the patient** (If greater than 18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription Policy & Agreement**

All patients are required to sign this Prescription Policy & Agreement. Failure to adhere to the rules and regulations of this agreement could result in the dismissal of your care from DCS Family Health Clinic.

**I, agree to the following in conjunction with my treatment under the supervision of the providers of DCS Family Health:**

1. Medication refill appointments must be scheduled at least 7-10 days in advance. It is the patient's responsibility to keep track of the amount of medication remaining and to schedule appointments appropriately.
2. Take medications as prescribed. Early refills will NOT be given. If you use up all your medications earlier than the scheduled refill date, the remaining days will be endured with no medications. You also have the option of going to the emergency room to treat your pain if it were to become unbearable.
3. All narcotics must come from one provider. You must notify our doctors if any narcotics medication orders made by other providers while under the care of DCS Family Health Clinic.
4. Refills of controlled substance medications will be made only during regular business hours. Monday through Friday, in person, once each month during scheduled office visits. Refills will not be made at night, on holidays or weekends.
5. Refills will not be made if you "run out early" or "lose a prescription" or "spill or misplace any medications" or "have medication stolen from me" or for any other reason. You are responsible for taking the medication in the dose prescribed & for keeping track of the amount remaining.
6. Refills will not be made as an "emergency" such as a Friday afternoon because "I suddenly realized that I will run out tomorrow". You will call at least 72 hours ahead if you need assistance with a controlled substance medication prescription.
7. All medications are to be kept in a safe place, especially away from children. They may be hazardous or lethal should they be inadvertently taken by any person other than for whom they were prescribed.
8. All medications must be obtained at a designated pharmacy.
9. The prescribing provider has complete liberty to fully discuss all diagnostic and treatment details with the dispensing pharmacy for the purposes of maintaining accountability.
10. Random urine/serum toxicology screening may be done at any time. Failure to comply with random drug screens is reasonable cause for discharge from DCS Family Health Clinic,
11. Script Altering is a federal offense and we will report any violations to the proper authorities.
12. Should your prescription need to be changed prior to your due date, all unused medications must be brought back to this office and disposed of properly prior to receiving your new prescription.
13. We reserve the right to communicate with previous and present provider that have cared for you and /or your previous or present insurance carriers.

If drug dependence, tolerance or addiction occurs, I agree to fully accept full responsibility for the risks taken secondary to my consent of narcotic consumption for the management of my condition. Should withdrawal symptoms be encountered, I will notify DCS Family Health Clinic. This medication should be stopped slowly through tapering; Medication is not to be stopped on your own without medical advice. **Evidence of medication hoarding, increasing use of medication without communication to the clinic staff, hostile behavior towards our staff, refilling your medication too frequently, getting the medication from multiple providers or pharmacies, increasing amounts of medication, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives, street or illicit drugs) during controlled substance treatment or other unacceptable behavior may result in dismissal from DCS Family Health Clinic.**

Side effects of narcotic medications may include drowsiness, dizziness, constipation, nausea and/or confusion. Risk of psychological dependence with the use of these medications may occur. Physical dependence is frequently encountered in the use of long term controlled substance therapy. Medication needs to be withdrawn gradually to avoid uncomfortable withdrawal symptoms that may include: excessive tearing, runny nose, dilated pupils, "goose pimple" flesh, sweating, yawning, diarrhea, muscle aches, headaches and insomnia. Tolerance to the use of narcotic medication may occur, decreasing its effectiveness.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                      Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian's Signature** (If patient is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of the patient** (If greater than 18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 **19100 Dr. John Lambert Drive-Hammond, LA 70403-Ph: 985-247-4567-Fax: 985-467-0896**

[www.dcsclinic.com](http://www.dcsclinic.com)

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: Whom it may Concern:

I This will be my authorization to allow DCS Family Health Clinic To examine any and all of my medical records; to obtain at his, its, or their expenses, photocopies of such records as he, it or they may desire; to discuss my medical history, examination and treatment with physicians, nurses, and other health care providers who have treated or examined me.

I specifically waive the limitations and restrictions place upon disclosure and discrimination of such information and records by Louisiana Revised Statute 13:3734, as amended by act 477 of the regular session of the Louisiana Legislature of 1985.

I further agree that this authorization shall be valid and effective unless and until it is revoked by me in writing and that a photocopy of this authorization may serve as an original.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                      Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian's Signature** (If patient is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of the patient** (If greater than 18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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