E&Y Medical Clinic Rehabilitation Center, Inc.
Controlled Substance Agreement

Between Patient: _____ and Doctor _____

The Florida Legislature has laws governing the prescription of controlled drugs. These drugs include all narcotics (such as codeine, hydrocodone, and oxycodone), sleeping aids, benzodiazepines (such as Valium, Xanax, and Ativan), and ADHD medications such as Concerta, metadata, Ritalin, and Vynanse). To comply with these laws, I acknowledge and agree to the following:

1. Prescriptions for most controlled substance medications can only be written for a 30-day supply.
2. I agree that only my physician will prescribe controlled substance medication. I will not obtain or use any controlled substances from a source other than my physician. I will instruct my other physicians to confer with my physician for any changes or need for additional controlled substance medication. If it is discovered that other providers are prescribing medications for me, my physician reserves the right to discontinue prescribing medications and/or discharge me from the clinic.
3. Refills must be written (i.e., they cannot be faxed or phoned in). I will need to come in and pick up the prescription. All medicine should be filled at the same pharmacy, when possible. The pharmacy I have selected is: (Name/phone)

   _____
4. My physician's office requires a 72-hour notice to refill prescriptions. Prescriptions can only be refilled during normal business hours. They will NOT be refilled at night or on weekends. I must provide proof of identity to pick up my prescription for controlled substances.
5. I must be seen by my doctor every 3 months to continue to get refills.
6. My physician's office is not responsible for any controlled substance medications that have been misplaced, lost, or stolen. Controlled substances cannot be refilled before the renewal date.
7. Routine blood work and random urine drug screens may be part of my treatment plan. I agree to have them done on the day my physician requests it.
8. If I do not follow these policies, my physician will not be able to continue to prescribe these medications for me.
9. It is a crime to obtain narcotics under false pretenses. This could include getting medications from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed, or diverting the medications in any other way (selling). If my physician has reason to believe that I have violated this agreement, the physician has the right to notify and cooperate with law enforcement. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my records.
10. My physician has the right to discontinue controlled substance medications and discharge me from care if any of the following occur.
    a. I trade, sell, misuse, or share medication with others;
    b. The clinic discovers I have broken any part of this agreement;
    c. I do not go for blood work or urine tests when asked;
    d. My blood or urine shows the presence of medications that my physician is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for;

e. I get controlled substances from sources other than E&Y Medical Clinic Rehabilitation Center, Inc. physician's
f. I exhibit any aggressive behavior towards the physicians or staff;
g. I consistently miss appointments.

I hold E&Y Medical Clinic Rehabilitation Center, Inc. physicians harmless from any liability in the event I am dismissed from the practice for failure to abide this agreement. I have read and understand the above policy.

_____ _____
Patient/Guardian Signature Date

_____ _____
Printed Patient's Name Date of Birth

_____
Witness

Consent for Treatment

I understand that the Physician and Physician's Assistant (PA) work together as a team to provide my medical treatment. I also understand that this office staffs both Physicians and Physician's Assistants and I will be treated by either one that is available at the time of my visit.

Consent for Medical Treatment

Knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by my physician, his/her consignees as may be necessary and his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examinations in the hospital.

This agreement will remain in effect until otherwise stated by me.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Signature Date

E&Y Medical Clinic Rehabilitation Center, Inc.
6718 N. Himes Ave, Suite B, Tampa, FL, 33614
Phone: (813) 353-3600 | Fax: (813) 353-3962 | Email: admin@eymedicalclinic.com

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that has been given to you. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. You are encouraged to read it in full.

The Notice of Privacy Practices is subject to change. If any changes are made, you may obtain a copy of the revised notice from me by contacting the office at (813) 353-3600.

If you have any questions about the Notice of Privacy Practices, please contact the office at 6718 N. Himes Ave, Suite B, Tampa, FL, 33614, or call us at (813) 353-3600.

I acknowledge receipt of the Notice of Privacy Practices of E&Y Medical Clinic Rehabilitation Center, Inc.

_____ _____

Patient/Parent/Conservator/Guardian Signature Date

Inability to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

This office made good faith attempts to obtain the patient's acknowledgment of his/her receipt of Notice of Privacy Practices including _____. However, because of _____ we were unable to this patient's acknowledgment.

_____ _____

Signature Date

Assignment of Benefits

I, _____, hereby instruct and direct my insurance company pursuant to Florida Statute F.S. 627.422 to pay by check or draft made out to and mailed directly to the above-named provider for professional or medical services. And any reimbursements otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by them. The payment to not exceed my indebtedness to the above named provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP Disability, or any other Health or Medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above-named provider.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above-named provider. This assignment also includes that right to recover any attorney fees and costs for such an action brought by the provider as my assignee.

I also agree that the above-mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company. All self-pay patients are expected to pay for services in full at the time services are rendered. Ultimately, payment responsibility rests with you, the patient.

I also authorize the release of any information pertinent to my case or claim to the above named provider or any attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above-named provider to file any formal or informal complaints that are necessary to the Insurance Commissioner's Office or any other agency or court they deem appropriate on my behalf.

Patient Name: _____ Date: _____
Print your name

Patient Signature: _____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____
Home Phone: _____ Cell Phone: _____
Address: _____
City: _____ State: _____ Zip : _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is allowed to make the disclosure:
   E&Y Medical Clinic Rehabilitation Center, Inc.
   6718 N. Himes Ave, Suite B, Tampa, FL, 33614
3. The type and amount of information to be used or disclosed is as follows:
   ____ Complete Health Records ____ Lab Results/X-Ray Reports
   ____ Physical Exam ____ Consultation Reports
   ____ Immunization Record
   ____ Other (Please Specify): _____
4. I understand that the information in my health record may include information relating to sexually transimitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   For the purpose of: □ Continued Medical Care □ Personal □ Legal □ Other: _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless othewise revoked, this authorized will expire on the following date, event, or condition: _____
7. If I fail to specify an expiration date, event, or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuseto sign this authorization. I need not sign this form in order to adure treatment. I understand that I mya inspect of copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information curries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient/Legal Representative Signature of Witness

_____ _____
Date (mm/dd/yyyy) Date (mm/dd/yyyy)

This information has been disclosed to you confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written, and informed release of the individual with whom it pertains or as permitted by federal law 42 CFR, part II.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Date: _____
I authorize: _____
Address: _____
Phone: _____
Fax: _____

To release information from the medical record of:

_____ _____ _____
(Patient's Full Name) (Date of Birth) (Social Security)

Reason for Request: _____
To: _____

ATTN: **Medical Records Department**
For the purpose of review/examiniation, I authorize you to provide the following information:

____ Complete Copy of Medical Record ____ X-Ray/MRI Reports
____ Other: _____

I give specific permission to release any information related to:

____ Substance Abuse ____ Psychiatric/Mental Health Information
____ HIV/AIDS Information

This authorization will expire one year from the date signed. I understand that i may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that this information is no longer protected by HIPAA if I am releasing this information to an entity or individual not covered by HIPAA.

Patient's or Legan Guardian's Signature: _____

Relationship to Paitent: _____

Witness: _____ Practice: _____

Identifying Information:

Name at time of treatment, if other than above: _____

Date of Treatment: _____

Date of Birth: _____ SS#: _____