Patient Information/ Financial Responsibility

Patient Name: _____

Address: _____

City_____ State _____ Zip _____

Home # _____ Cell # _____ Work/Alternate # _____

DOB _____ SS#_____

E-mail address: _____ Employed by: _____

Occupation: _____ (If Minor) Parent/Guardian Name_____

Emergency Contact: _____Phone # _____

Pharmacy Name _____ Pharmacy Location _____

CONSENT FOR TREATMENT: I authorize the physicians at Coastal Plus Medical Center, Inc to provide medical and surgical care to myself and/or my minor children. The signed statement will serve as my authorization for the treatment of my minor children if I am unavailable. I authorize all diagnostic testing including laboratory studies and x-rays studies as well as any treatment modality that the physician deems appropriate in my medical care. I understand that Coastal Plus Medical Center, Inc is strictly for non-emergent medical care. I acknowledge that if any medical problem occurs during the hours that Coastal Plus Medical Center, Inc is not open, I have been advised to be evaluated and treated at a hospital emergency room or by another physician of my choice.

ASSIGNMENT OF BENEFIT:
I hereby authorize payment to be assigned by my insurance company directly to the physicians at Coastal Plus Medical Centers. PLEASE DIRECT ALL MEDICAL BENEFITS TO THEIR OFFICE. I authorize the release of any information acquired in the course of my examination and/or treatment that may be needed to facilitate payment for the medical services rendered. I accept financial responsibility for any and all payment not received from my insurance carrier.

RELEASE OF MEDICAL RECORDS: I give my consent to Coastal Plus and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of Coastal Plus or its agents suspect illegal activity. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by Coastal Plus without order of the clerk or court.

CONTROLLED MEDICATION AGREEMENT:
I understand that I may be receiving a prescription(s) for controlled medication. I understand that I am fully responsible for the prescription(s) before and after the prescription(s) is (are) filled. By signing this you give Coastal Plus the right to directly communicate with other healthcare providers, pharmacies and law enforcement regarding the controlled substances we prescribe if a violation should arise.

In the event that the prescription(s) or the medication(s) is (are) lost, destroyed, or stolen, the physicians will NOT rewrite or refill a replacement prescription for the same or any other controlled medication(s). Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.

FINANCIAL RESPONSIBILITY: I hereby acknowledge and accept financial responsibility for all medical services rendered to me and/or my minor children, by the physicians at Coastal Plus Medical Center, Inc. I agree to remit payment in full at the time services are rendered.

ACKNOWLEDGEMENT OF PRIVACY ACT:
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

NOTICE:
We require 24-hour notice for canceling any appointments. There is a $30.00 charge for weekday appointments if they are not canceled OR if 24-hour notice is not given. If you are 10 minutes or more late for your appointment, we reserve the right to cancel that appointment and require you to reschedule. Any charge backs to credit cards will result in your account being made a cash only accepted payment type account. A $35.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred. We charge for medical records, and all disability, FMLA, work and/or insurance paperwork. The medical record fee may vary on # of pages; the paperwork fee is $25.00 flat fee.

Signature _____ Date _____

11761 Beach Blvd Ste 8. Jacksonville, Fl 32246.

ASSIGNMENT OF INSURANCE BENEFITS, DIRECTION TO PAY AND AUTHORIZATION FOR INSURANCE INFORMATION

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and to directly pay COASTAL PLUS MEDICAL CENTER, INC. for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of COASTAL PLUS MEDICAL CENTER, INC. This assignment of insurance benefits pertains to any and all professional services, including past services, provided by COASTAL PLUS MEDICAL CENTER, INC. in relation to my health insurance and/or motor vehicle accident of _____.

This assignment of insurance benefits is provided so that COASTAL PLUS MEDICAL CENTER, INC. may attempt to collect any unpaid or overdue insurance benefits from the insurance carrier. This includes the assignment of any cause of action that might accrue against such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to COASTAL PLUS MEDICAL CENTER, INC. needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize COASTAL PLUS MEDICAL CENTER, INC. to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf.

I understand that there may be services provided that may not be paid under the benefits of my insurance plan and therefore I am responsible to pay for these services in addition to any co-payment amounts.

A copy of this agreement will be as valid as the original.

I have read and I do understand this Assignment of Benefits thoroughly.

Patient's Signature: _____

Signature of Legal Guardian: _____ Date: _____

(when patient is a minor child)

Patient History

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NAME **DATE OF BIRTH** **DATE**

OCCUPATION: _____ **MARITAL STATUS:** _____

CHILDREN/AGE: _____

MAIN PROBLEMS **ADDITIONAL INFORMATION**

1.

2.

3.

ALLERGIC TO:

LIST ALL MEDICATIONS YOU ARE NOW TAKING

1. **3.** **5.**

2. **4.** **6.**

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR SURGERY	YEAR	ILLNESS OR SURGERY
Not Including Pregnancies				

Smoking Y N How many packs per day? # years **Alcohol** Y N How many per week? # years

PAST MEDICAL HISTORY (DO NOT include today's symptoms) PLEASE CHECK ALL THAT APPLY

☐ Heart Problems
☐ Heart Attack
☐ Heart Valve Problems
☐ Mitral Valve Problems
☐ Heart Failure
☐ High Blood Pressure

☐ Stroke
☐ Lung Problems
☐ Asthma

☐ Emphysema/COPD
☐ Bronchitis
☐ Diabetes
☐ Diabetes - Pregnancy
☐ Glaucoma
☐ Kidney Stones
☐ Thyroid/Goiter Problems
☐ Ulcers
☐ Hepatitis
☐ Cancer

☐ HIV/AIDS
☐ History of STD's

☐ Rheumatic Fever

☐ Scarlet Fever
☐ Tuberculosis
☐ Anemia/Sickle Cell
☐ Gout
☐ Chicken Pox
☐ Polio

☐ Mumps
☐ Measles
☐ German Measles

☐ Chronic Fatigue
☐ Osteoporosis
☐ Chest Pain
☐ Chest Pressure
☐ Chest Tightness
☐ Palpitations
☐ Fainting/Dizzy Spells
☐ Shortness of Breath
☐ Difficulty Breathing
☐ Wheezing

☐ Cough
☐ Leg Blood Clots
☐ Swollen Ankles/Varicose Veins

☐ Diarrhea
☐ Constipation
☐ Bloody or Tarry Stools
☐ Diverticulitis
☐ Abdominal Pain
☐ Hemorrhoids/Hernia

☐ Difficulty Swallowing
☐ Heartburn
☐ Nausea & Vomiting

☐ Weight Loss
☐ Loss of Appetite - recent
☐ Weight Gain - recent
☐ Indigestion/Ulcers
☐ Kidney/Bladder Problems
☐ Frequent Urination
☐ Burning Urination
☐ Night Urination - frequent
☐ Blood in Urine
☐ Nose Bleeds – recurrent

☐ Sinus Trouble
☐ Sore Throats - frequent

☐ Hayfever/Allergies

☐ Hoarseness-prolonged
☐ Arthritis/Rheumatism
☐ Back Pain
☐ Shoulder Pain
☐ Knee Pain
☐ Multiple Pain Location

☐ Bone Fracture/Joint Injury
☐ Accidents (Auto or Falls)
☐ Foot Pain
☐ Injuries – neck, back, knee, spine
☐ Gallbladder Disease
☐ Seizures/Convulsions
☐ Hearing Problems
☐ Headaches - frequent
☐ Rashes/Hives
☐ Psoriasis
☐ Eye Pain/Problems
☐ Double or Blurred Vision
☐ Depression

☐ Nervous Disorders
☐ Emotional Disorders

Females – Please Complete
Possibly Pregnant? Y N
Menstrual Flow
☐ Regular
☐ Irregular
☐ Pain/Cramps
1st day of last period: _____
☐ Pain/Bleeding during or after sex
Number of:
☐ Pregnancies _____
☐ Miscarriages _____
☐ Abortions _____
☐ Live Births _____
Birth Control Method:
☐ Pill: _____
☐ Other: _____
☐ Flushing/Menopause
Date of last PAP test :_____
☐ Normal
☐ Abnormal
Date of last Mammogram: _____
☐ Normal
☐ Abnormal

Family History: Please specify any blood relatives who had the following:

DIABETES _____ THYROID _____
ASTHMA _____ HEART DISEASE _____
STROKE _____ HYPERTENSION _____
CANCER WHAT KIND:

11761 Beach Blvd Ste 8. Jacksonville, Fl 32246.

Patient Request for Copies of Records and Authorization for Release of Information and Accounting Disclosures

Name_____
Date of Birth _____ SSN: _____
Address_____
City _____ State _____ Zip Code _____

I hereby request and authorize copies of and/or release of my medical records and or x-rays from/to Coastal Plus Medical Center:

From:_____ To: _____
_____ _____
_____ _____

For the Purpose of: _____ For Treatment Dates:_____

Circle: Imaging/Radiology Labs Office Notes Entire Record Other: _____

_____ I acknowledge and hereby consent to such, that the released information may contain alcohol drug abuse, psychiatric, HIV testing, HIV results, or AIDs information.
_____ I, undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand this authorization may be revoked by me at any time, expect to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with the "Authorization for Release of Information".
_____ I hereby authorize Coastal Plus Medical Center to release a copy of my patient records or x-rays containing protected health information to. This authorization is given pursuant to Florida Statue 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representation.
_____ This authorization expires 180 days from the date signed below and covers treatment for the dates specified above. Fees/charges will comply with all laws and regulations applicable to release of information.
_____I understand that Section 460.413 (1) (m), Florida Statues, and Board of Chiropractic Medicine Rule 64B2-17.006 require chiropractic physicians to retain records and x-rays for at least four years. Therefore, a chiropractic physician receiving a request for a patient's x-ray within that four-year period must retain the x-ray and provide a copy of it in lieu of the original x-ray. I, further, understand that Section 456.057 (18), Florida Section 457.057 (16), Florida Statutes, authorizes a health care practitioner or patient records owner furnishing copies of reports or records or making the reports or records available for digital scanning pursuant to this section to charge no more that the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the department when there is no board, The Board of Chiropractic Medicine Rule 64B-17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge patients $1.00 per page for the first 25 pages, and 25 cents for each page in excess of 25 pages, The Board of Chiropractic Medicine Rule defines the reasonable costs of reproducing x-rays, and such other special kinds of records as the actual costs, The phrase "actual costs" means the cost of the material and supplies used to duplicate the records, as well as the labor costs and overhead costs associated with such duplications. The Board of Chiropractic Medicine Rule 64B17.0055, Florida Administrative Code, authorizes chiropractic physicians to charge people who are not patients authorized to seek copies of my patient records $1.00 per page. I understand that the HIPAA regulations authorize the practice to charge the cost of labor and hardware onto which the records are electronically copied unless the Board of Chiropractic Medicine sets lower costs. I understand that there is no cost for transmitting the electronic records by email.
_____There is a record of any and all disclosures of information contained in the medical record to any third party, including the purpose of the disclosure, required to be maintained by Florida Statute 456.057 (12) and provided to a patient upon request pursuant to HIPAA regulations. This record/form shall be maintained as part of the patient's records pursuant to Florida Statue 456057 (12). A copy of this form shall be provided to any patient requesting an accounting or a copy of their patient records. This form will be maintained as part of the medical records for at least six years. I am aware I can request a list of disclosures at any time.

_____ _____ _____
Date Patient/Parent/Guardian Relationship to Patient

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www.coastalcareplus.com

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a result of the patients injured sustained in an automobile accident that occurred on _____.

2. The basis for the finding of an Emergency Medical Condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to the patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

_____ _____ _____
Name (Print or Type) Signature of medical provider Date

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate.

2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injured I suffered in the car accident.

3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

_____ _____ _____
Name (Print or Type) Signature of injured patient/guardian Date

Faxed on:_____ By:_____

NOTICE OF INITIATION OF TREATMENT

Per Florida Statue 627.736(5) (c) 1.

Coastal Plus Medical Center, Inc is notifying you of our intentions to treat:

Patient Name:_____

Patient Date of Birth:_____

Patients Auto Insurance Company Name:_____

Patients Claim number:_____

Date of Accident:_____

Adjustor name: _____

Adjustor phone:_____

Adjustor Fax: _____

Patients Medical Insurance Company Name: _____

Patients Member ID or Policy Number: _____

Pursuant to Florida Statute 627.736(5)(c)1., you are hereby notified that treatment on your insured, _____ was initiated on _____ for injuries sustained in a motor vehicle accident that occurred on _____. This patient will be treating with Coastal Plus Medical Center, Inc. Tax ID 27-2268890.

Respectfully,

Coastal Plus Medical Center

11761 Beach Blvd Ste 8. Jacksonville, Fl 32246.

Motor Vehicle Accident Patient Questionnaire

(for office use) Vitals: HT _____Wt_____ BP_____ P_____ Resp_____ Temp_____ LMP_____ O2_____

Patients NAME: _____ Date of Accident_____

Please list your personal healthcare insurance if you have any coverage?_____

Where did accident happen? Describe the accident in your own words, location, impact etc: _____

_____

_____

Current PAIN level (1 to 10 scale, 10 being worst) circle one: 1 2 3 4 5 6 7 8 9 10

Chief Complaints/ Main Problems/ Injuries/ Symptoms:

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

(Associated Signs & Symptoms)Following the accident, have you experience any of the following? ___ dizzy/dazed/lightheaded ___disoriented ___nervous ___nauseous ___upset ___weakness ___abdominal pain ___headache ___ anxiety ___ visual issues ___shortness of breath ___fatigue ___excessive irritability ___fear of driving in a car ___a loss of concentration ___jaw clenching ___grinding of teeth at night ___nightmares ___difficulty sleeping ___muscle spasms ____difficulty walking ___ decreased range of motion ____ other: _____

Auto accident details (Please Circle):

Seatbelt: YES NO **Were you the:** Driver Passenger Rear Passenger Pedestrian Hit by Car

Did Airbags Deploy: YES NO

Your Vehicle: CAR TRUCK SUV Motorcycle BUS SEMI BIKE **Accident with:** CAR TRUCK SUV Motorcycle BUS SEMI BIKE

Type of impact: Rear-ended T-boned Hit head on Side impact **Body moved:** Forward/Backward Backward/Forward Side-to-Side

Head jerked: Forward/Backward Backward/Forward Side-to-Side **Were you braced:** YES NO **Were brakes applied**: YES NO

Did you strike anything in your car: YES NO (if Yes, what):_____

Did the seat back bend or break ? YES NO **Was Your Vehicle:** Stopped Moving

Were you looking: Straight Ahead To the Right To the Left **Headrest aligned:** Top of Head Middle of Head Bottom of Head

Did you have a Loss of Consciousness: YES NO **Prior Medical Care like Emergency Room visit:** YES NO

If yes, where, what Hospital: _____ **Did you bring the Records:** YES NO

Are you experiencing any of the following?

Neck pain: *check off the areas that the pain radiates or travels to*:

__none ___left shoulder ___right shoulder ___left arm ___right arm ___left forearm ___right forearm
___left hand ___right hand ___headache ___Migraine Headache ___upper back pain

Jaw Pain: Yes No Left Right Both Sides

Ringing in Ears : Yes No Left Right Both Ears **Blurry Vision** : Yes No Left Right Both Eyes
Shoulder Pain: Yes No Left Right Both Shoulders **Arm Pain**: Yes No Left Right Both Arms
Wrist Pain: Yes No Left Right Both Wrists **Hand Pain**: Yes No Left Right Both Hands

Low Back Pain: *select the areas of radiation, if any...*

___none ___buttocks ___left buttock ___right buttock ___left thigh ___right thigh ___left knee ___right knee ___left foot ___right foot

Hip Pain: Yes No Left Right Bilateral **Knee Pain**: Yes No Left Right Bilateral
Ankle Pain: Yes No Left Right Bilateral **Foot Pain**: Yes No Left Right Bilateral

Numbness in any of the following areas:

___Left Hand ___Right Hand ___Left Upper Arm ___Right Upper Arm ___Left Leg ___Right Leg ___Left Foot ___Right Foot

Difficulties with Daily Activities: *check all that apply*

___work related ___entertainment/social ___grooming ___bathing ___dressing ____sleeping ___caring for self/family ___other

Lost time from work? Yes No If yes, dates: _____ **Type of employment**: _____ **Previous injuries or accidents**? Yes No **Residual pain from the prior injury**? Yes No

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been Provided.** _____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____ _____ _____
Name *(PRINT or TYPE)* Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.
D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

_____ _____ _____
Name *(PRINT or TYPE)* Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

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OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.** _____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____ _____ _____

Name *(PRINT or TYPE)* Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.
D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/her **own hand**)*:

_____ _____ _____

Name *(PRINT or TYPE)* Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1571
Pub. 1/2004

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Controlled Medication Agreement

I, _____ , understand that I may be receiving a prescription(s) for controlled medication. I understand that I am fully responsible for the prescription(s) before and after the prescription(s) is (are) filled. By signing this you give Coastal Plus the right to directly communicate with other healthcare providers, pharmacies and law enforcement regarding the controlled substances we prescribe if a violation should arise.

In the event that the prescription(s) or the medication(s) is (are) lost, destroyed, or stolen, the physicians will NOT rewrite or refill a replacement prescription for the same or any other controlled medication(s). Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.

I understand while I am receiving controlled medications from Coastal Plus I am not to seek any other medical providers out for the same or similar controlled medication. Violating this will result in me discharged from care. By signing the following, I state that I have not received any prescription for any controlled medication from any other physician since my last prescription for a controlled medication at Coastal Plus Medical Centers. The patient also authorizes us and any other healthcare provider, pharmacy, law enforcement, or judiciary body to receive and/or release any pertinent information regarding the patient's prescription or urine/blood screen as the result of a violation of this agreement.

****Violation of this policy will result in dismissal from care****

- ❑ **I HAVE NOT received any prescription for a controlled medication from ANY physician in the last three (3) months.**

- ❑ **I HAVE received one or more prescriptions for a controlled medication in the past three (3) months from the following physicians:**

NAME OF MEDICATION RECEIVED	**NAME OF PRESCRIBING PHYSICIAN**

PATIENT SIGNATURE _____ **DATE** _____

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