901 River Front Parkway, Ste 100
Chattanooga, TN 37402
423-756-7134

The Plastic Surgery Group, PC
Hayes Hand Center

1949 Gunbarrel Road, Ste 303
Chattanooga, TN 37421
423-756-7134

D. Marshall Jemison, MD • Mark A. Brzezienski, MD • Jason P. Rehm, MD
Jimmy L. Waldrop, MD • Todd E. Thurston, MD

PATIENT CONSENT AND ASSIGNMENT FORM

Patient Name: _____ **DOB** _____ **MR#** _____

I. Consent to Treat

I authorize The Plastic Surgery Group, PC and Hayes Hand Center which is a division of The Plastic Surgery Group, its health care practitioners, staff, office surgery facility and other individuals involved in my care to examine me and perform any tests, procedures and/or treatments that may be helpful to care for my injury or illness.

I understand that The Plastic Surgery Group, PC and Hayes Hand Center is dedicated to teaching, that authorized resident physicians my observe and assist in diagnosis, treatment and care, and that photographs may be taken for purposes of diagnosis, teaching and documentation. I reserve the right to give specific permission for publication of any picture that personally identifies me.

II. Payment and Financial Obligations

I request **that payment of authorized Medicare and/or other insurance company benefits be made to The Plastic Surgery Group, PC / Hayes Hand Center** for any services furnished to me my that physician/supplier. I authorize any holder of medical information about me to release to Medicare and/or other insurance companies and its agents any information needed to determine benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare and/or other insurance company assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare and/or other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered insurance services. Coinsurance and the deductible are based upon the charge determination of the Medicare and/or other insurance company.

I understand that I am responsible for paying all charges associated with this treatment. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third party who is responsible for payment. I am also responsible for those charges not covered by my insurance such as deductibles, co-pays or evaluation or treatment that are not included as an insurance benefit. I understand that if my insurance plan requires a referral, prior authorization for surgery and/or a second surgical opinion and this has not been obtained, I am responsible for payment of services rendered.

I authorize my health insurance carrier(s) or other third parties who are responsible for paying for my health care to pay costs associated with my evaluation and care directly to The Plastic Surgery Group, PC / Hayes Hand Center.

I authorize the release of any medical information necessary to process this claim. I realize that in the event these claims are denied I am responsible for payment. I authorize my private health insurance carrier to reimburse The Plastic Surgery Group, PC / Hayes Hand Center in the event that Workers' Compensation denies payment. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

III. CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to The Plastic Surgery Group. PC / Hayes Hand Center, its health care practitioners, staff and other individuals, use and disclosure of my **protected health information ("PHI")** in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice. I consent to The Plastic Surgery Group, PC / Hayes Hand Center **disclosure of PHI to other health care practitioners and facilities** that are involved in providing medical services to me.

901 River Front Parkway, Ste 100
Chattanooga, TN 37402
423-756-7134

The Plastic Surgery Group, PC
Hayes Hand Center

1949 Gunbarrel Road, Ste 303
Chattanooga, TN 37421
423-756-7134

D. Marshall Jemison, MD • Mark A. Brzezienski, MD • Jason P. Rehm, MD
Jimmy L. Waldrop, MD • Todd E. Thurston, MD

PATIENT CONSENT AND ASSIGNMENT FORM

Patient Name: _____ **DOB** _____ **MR#** _____

Also, I consent to The Plastic Surgery Group, PC / Hayes Hand Center disclosure of PHI to my health insurance carrier, utilization review organization, or third-party administrator to support payment for my medical services.

I understand that The Plastic Surgery Group, PC / Hayes Hand Center's **agreement to provide medical services to me** is conditioned upon my signing of this consent and that The Plastic Surgery Group, PC / Hayes Hand Center requests my consent to ensure that The Plastic Surgery Group, PC / Hayes Hand Center can properly carry out the professional responsibility of caring for me.

I understand that The Plastic Surgery Group, PC / Hayes Hand Center will disclose only the minimum of my health care information that is necessary, in the judgement of The Plastic Surgery Group, PC / Hayes Hand Center for the legitimate needs of the recipient or for my general wellbeing.

My PHI which is the subject of this consent includes demographic information, information about my physical or mental health or condition, information about the medical services provided to me (including payment information) if any of that information may be used to identify me. (Depending upon the medical services I request or require this information may include information about treatment for HIV/AIDS, sexually-transmitted diseases, mental health or psychiatric conditions, or substance abuse.)

I understand that I have a right to restrict The Plastic Surgery Group, PC / Hayes Hand Center's use and disclosure of my PHI and that The Plastic Surgery Group, PC / Hayes Hand Center is not obligated to agree to the requested restriction, but that an agreement to a restriction binds The Plastic Surgery Group, PC / Hayes Hand Center. I may revoke this consent at any time by providing The Plastic Surgery Group, PC / Hayes Hand Center with a written, signed and dated request except to the extent that The Plastic Surgery Group, PC / Hayes Hand Center has acted in reliance upon my consent. However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial or coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge that this consent will remain in effect for al subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent unless I revoke it earlier as described above.

I have received a copy of The Plastic Surgery Group, PC / Hayes Hand Center's Notice of Privacy Practices that provide a more complete description of the uses and disclosures addressed above and I have had an opportunity to review the Notice of Privacy Practices before signing this consent. I acknowledge that the Plastic Surgery Group, PC / Hayes Hand Center reserve the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting the office staff at any time.

From time to time our practice communicates with patients about products and services we believe would be beneficial to our patients through mail and/or through email. This may include information about sales and special discounts, and information about upcoming events, seminars and our practice news. Your information will no be sold, distributed or traded. You may request removal from our mailing lists at any time.

_____ Yes, I would like to receive occasional mailings. My email address is _____

_____ No, I do not wish to receive any mailings.

I understand that if I have any questions about this consent or about The Plastic Surgery Group, PC / Hayes Hand Center's privacy practices, or if I wish to have a copy of this consent, I may ask the office staff or my physician.

Signature of Patient or Parent/Legal Guardian	Printed Name	Date

The Plastic Surgery Group
Hayes Hand Center
Patient Information Form

MR#

D. Marshall Jemison, MD, Mark A. Brzezienski, MD
Jason P. Rehm, MD Jimmy L. Waldrop, MD Todd E. Thurston, MD

Patient Name	Last	First	Middle
Date of Birth / /	Age		Sex ❑ Male ❑ Female
Social Security #			
Address			
City	State		Zip
Home Phone	Mobile		Work
Marital Status ❑ Married	❑ Single	❑ Divorced	❑ Separated ❑ Widowed
Race: ❑ American Indian ❑ Asian ❑ African American ❑ Caucasian ❑ Undefined			
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported ❑ Refused to Report ❑ Undefined			
Language Preference			
Employer			
Spouse's Name	DOB		Social Security #
Spouse's Employer			Work Phone #
Emergency Contact	Relationship		
Emergency Contact Number			

DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results or release of medical information including but not limited to, appointment times, lab or test results, etc. will be provided to the patient only. Please specify below whom information may be released to other than yourself. I grant permission for The Plastic Surgery Group, PC to release any and all of my medical information to the person(s) listed below.

Patient Signature:_____

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

May we leave messages at your: ❑ Home Answering Machine ❑ Cell Phone ❑ Work Voice Mail ❑ E-Mail

Email Address:_____

Preferred Notification Method: ❑ Mail ❑ Web Message

TPSG Communicates PHI to you through secure email. However, unless you have secure email on your media device, communications from you are over public wire. There should be no assumption of confidentiality when using email over public networks.

The Plastic Surgery Group
Hayes Hand Center
Patient Information Form

MR#

D. Marshall Jemison, MD, Mark A. Brzezienski, MD
Jason P. Rehm, MD Jimmy L. Waldrop, MD Todd E. Thurston, MD

PLEASE COMPLETE ALL SECTIONS

FINANCIAL INFORMATION

Person Responsible for Payment		Relationship to Patient
Address (if different from above)		
City	State	Zip
Home Phone	Work Phone	Mobile Phone

IF THE PATIENT IS A MINOR / STUDENT

Father's Name / Legal Guardian			Mother's Name / Legal Guardian		
Address (if different from pt.)			Address (if different from pt.)		
City	State	Zip	City	State	Zip
Social Security # - -	DOB:		Social Security # - -	DOB:	
Work Phone #			Work Phone #		
Home/Cell #			Home/Cell #		
Employer			Employer		

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO OUR FRONT DESK

PRIMARY INSURANCE NAME:		Subscriber's Name
Relationship to pt.	DOB	SS #
SECONDARY INSURANCE NAME:		Subscriber's Name
Relationship to pt.	DOB	SS #

COMPLETE THIS SECTION IF YOU ARE COVERED UNDER MEDICARE

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions.

Are you employed? ❑ Yes ❑ No	Is your spouse employed? ❑ Yes ❑ No
If Retired list date of Retirement / /	If Retired list date of Retirement / /
Please list employer information on front of form.	Please list employer information on front of form.
Please complete health plan information above.	Please complete health plan information above.

PLEASE COMPLETE THIS SECTION IF APPLICABLE

Are you eligible for coverage under Workers' Compensation/Job related? ❑ Yes ❑ No	
Date of first symptoms or date or injury:	
Is your injury / illness due to an accident? ❑ Yes ❑ No	
If yes, please complete the following:	
Name and address of auto insurance carrier:	
Name of Insured:	Policy or ID #
Accident Date:	State where accident occured:

ADVANCED DIRECTIVES

Do you have a Living Will or Durable Power of Attorney? ❑ Yes ❑ No

Please provide The Plastic Surgery Group, P.C. with a copy for your file. The Plastic Surgery Group, P.C. does not honor Advanced Directives/Living Wills and our policy is as follows. Regardless of any advanced directive if an adverse event occurs during your treatment at this office, we will initiate resuscitative or other stabilizing measures and transfer you to the nearest hospital for further evaluation. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this policy by your signature does not revoke or invalidate any current health care power of attorney.

The Plastic Surgery Group

Office Use Only: H&P3/12
Dr. #_____
Acct.#_____
B/P_____/_____T____P____R____
Height_____ Weight_____

Date:_____

Patient Name:_____ Date of Birth_____ Age:_____
Last First Middle

Referred By:_____ Primary Care Doctor_____

Reason for appointment_____

If applicable: Date of injury or onset of problem._____

Is this the result of a work or car accident? YES □ NO □

What makes the problem/pain worse or better?_____

Past Medical History: Have you ever been a patient in this office? YES □ NO □

IF ADDITIONAL SPACE IS NEEDED IN ANY SECTION OF THIS FORM ATTACH A SEPARATE SHEET.

List any current medical problems you have.

Medical Problem	Medical Problem

Have you ever had any problem with anesthesia? YES□ NO□ If yes, explain.

Surgical / Hospitalization History:

Type of Surgery or Hospitalization	Date	Type of Surgery or Hospitalization	Date

Allergies: List medications and/or foods that you are allergic to and what kind of reaction that you have?

Name of Medication	Reaction	Name of Medication	Reaction

Present Medications (Prescription or Non-Prescription)

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Social History

Student: YES □ NO □ Grade Level_____ Full time□ Part time□

Occupation_____ Employer_____ How long?_____

Marital Status: □Single □Married □Separated □Divorced □Widowed

Use of Alcohol: □Never □Rarely □Moderate (2 drinks /day) □Heavy (More than 2 drinks/day)

Tobacco Use: □Never □ Smoker ___Packs/Day □Previous smoker Date quit_____ □Chews Tobacco □Use Snuff

If you have children ages 0-17 list their ages._____

Family History

Any family history of medical problems? If so, please list.

Type of problem	Which family member	Type of problem	Which family member

Do you currently have, or have you ever had problems with: Circle Yes or No

HEENT
- □Allergic Rhinitis
- □Blurred/Double Vision
- □Cataracts
- □Ear Infections
- □Chronic Sinusitis
- □Ear Drainage
- □Earache
- □Nose Bleeds
- □Eye Disease
- □Eye Injury
- □Glaucoma
- □Head Injury
- □Hearing Loss
- □Mouth Sores
- □Nasal polyps
- □Ringing in Ears
- □Wears Glasses/Contacts

Musculoskeletal
- □Arthritis
- □Back Injury
- □Back pain
- □Cold Extremities
- □Difficulty Walking
- □Joint Injury
- □Joint Pain
- □Joint Problems
- □Joint Stiffness/Swelling
- □Low back pain
- □Muscle Pain/Cramps
- □Osteoporosis
- □Weakness
- □Weakness of muscles or joints
- □Fibromyalgia
- □Neck Pain

Psychiatric
- □Alcohol Abuse
- □Alzheimer's
- □ADD
- □ADHD
- □Bipolar Disease
- □Depression
- □Drug Dependency
- □Insomnia
- □Memory Loss or Confusion
- □Nervousness
- □Anxiety Disorder
- □Other

Cardiac
- □Angina Pectoris
- □Chest pain
- □Congestive Heart Failure
- □Coronary Artery Disease
- □Irregular Heartbeat
- □ Heart Disease
- □Hypertension (High Blood Pressure)
- □Hypotension (Low Blood Pressure)
- □Heart Attack
- □Swelling of feet, ankles, hands
- □Mitral Valve Prolapse

Cancer
- □Brain Cancer
- □Breast Cancer
- □Cervical Cancer
- □Colon Cancer
- □Ovarian Cancer
- □Prostate Cancer
- □Rectal Cancer
- □Skin Cancer
- □Stomach Cancer
- □Throat Cancer
- □Thyroid Cancer

Gastrointestinal
- □Ulcerative Colitis
- □Abdominal Pain
- □Colon polyps
- □Duodenal Ulcer
- □Gastric Ulcer
- □GERD
- □Heartburn
- □Hepatitis
- □Hiatal Hernia
- □Liver Disease
- □Nausea & Vomiting

Respiratory
- □Asthma
- □Chronic or Frequent Cough
- □COPD
- □Emphysema of Lung
- □Pneumonia
- □Shortness of Breath
- □Tuberculosis
- □Sleep Apnea

Hematology
- □Abnormal bleeding in your family
- □Anemia
- □Bleeding or Bruising Tendency
- □Known HIV/Aids Exposure
- □Phlebitis
- □Slow to heal after cuts
- □Transfusion History
- □Clotting Disorder
- □ Deep Venous Blood Clots

Skin
- □Rash or Itching
- □Varicose Veins
- □Change in Skin

Congenital
- □Facial Deformity
- □Skull Deformity
- □Hand Deformity
- □Cleft Lip
- □Cleft Palate

Endocrine
- □Diabetes Type I
- □Diabetes II
- □Excessive Thirst or Urination
- □Excessive Urination
- □Heat or Cold Intolerance
- □Hyperthyroidism
- □Hyperthyroidism
- □Glandular Hormone

Neurologic
- □Head Injury
- □Numbness & Tingling
- □Seizure Disorder
- □Stroke
- □Tremors
- □Migraine headache
- □Restless Leg Syndrome
- □Transient Ischemic Attack
- □ Parkinson's Disease

Breast
- □Breast Discharge
- □Breast Pain
- □Fibrocystic Disease
- □Lump in Breast
- □Cancer

Genitourinary
- □Hematuria
- □Incontinence
- □Kidney Disease
- □Urinary Frequency
- □Urinary Tract Infections
- □Urinary Tract Problem

PRESCRIPTION REFILL POLICY

Refills for Prescription Medications need to be called in to our office between 8:30a.m. and 4:00 p.m. Monday through Friday.
All approved prescriptions will be called into the pharmacy by the end of that business day.
Prescriptions should be taken "AS DIRECTED". Early refills may be defined.
NO medications will be refilled after hours, or on weekends.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

I have reviewed the above information with the patient.

The Hayes Hand Center

Office Use Only: H&P3/12
Dr. # _____
Acct. # _____
B/P ____/____ T____P____R____
Height _____Weight _____

Date: _____

Right		Left	
Grip	Pinch	Grip	Pinch

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ Age: _____

Referred By: _____ Primary Care Doctor: _____

Reason for appointment _____ Is this a result of a work or car accident YES ❑ NO ❑
Are you: ❑ Right Handed ❑ Left Handed ❑ Ambidextrous Which hand/arm is involved? ❑ Right ❑ Left ❑ Both
Date of injury or onset of pain: _____ On a scale of 1-10 (10 being worst) rate your pain _____
What makes the problem/pain worse or better _____

Past Medical History: Have you ever been a patient in this office? YES ❑ NO ❑

IF ADDITIONAL SPACE IS NEEDED IN ANY SECTION OF THIS FORM ATTACH A SEPARATE SHEET.

List Any Current Medical Problems You Have:

Medical Problem	Medical Problem

Have you ever had any problem with anesthesia? YES ❑ NO ❑ If yes, explain.

Surgical / Hospitalization History:

Type of Surgery or Hospitalization	Date	Type of Surgery or Hospitalization	Date

Present Medications: (Prescription or Non-Prescription)

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Allergies: List medications and/or foods that you are allergic to and what kind of reactions that you have?

Name of Medication	Reaction	Name of Medication	Reaction

Social History Student YES ❑ NO ❑ Grade Level _____ Full time ❑ Part time ❑
Occupation _____ Employer _____ How Long?_____
Martial Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate (2 drinks/day) ❑ Heavy (More than 2 drinks/day)
Tobacco Use: ❑ Never ❑ Smoker_____Packs/Day ❑ Previous Smoker Date Quit _____ ❑ Chews Tobacco ❑ Use Snuff
If you have children ages 0-17 list their ages. _____

Family History **If additional space is required attatch a separate sheet.**
Any family history of medical problems? If so, please list.

Type of problem	Which family member	Type of problem	Which family member

Do you currently have, or have you ever had problems with:

HEENT
- ❑ **ALLERGIC RHINITIS**
- ❑ Blurred/Double Vision
- ❑ **CATARACTS**
- ❑ Chronic Sinusitis
- ❑ Earache
- ❑ Ear Drainage
- ❑ Ear Infections
- ❑ **EYE DISEASE**
- ❑ Eye Injury
- ❑ **GLAUCOMA**
- ❑ Fever Blister
- ❑ Hearing Loss
- ❑ Mouth Sores
- ❑ Nasal Polyps
- ❑ Nose Bleeds
- ❑ Ringing in Ears
- ❑ Wears Glasses/Contacts

Musculoskeletal
- ❑ **ARTHRITIS**
- ❑ Back Injury
- ❑ Back pain
- ❑ Cold Extremities
- ❑ Difficulty Walking
- ❑ **FIBROMYALGIA**
- ❑ Joint Injury
- ❑ Joint Pain
- ❑ Joint Problems
- ❑ Joint Stiffness/Swelling
- ❑ Low back pain
- ❑ Muscle Pain/Cramps
- ❑ Neck Pain
- ❑ **OSTEOPOROSIS**
- ❑ Weakness
- ❑ Weakness of muscles or joints

Psychiatric
- ❑ **ADD**
- ❑ **ADHD**
- ❑ **ALCOHOL ABUSE**
- ❑ **ALZHEIMER'S**
- ❑ **ANXIETY DISORDER**
- ❑ **BIPOLAR DISEASE**
- ❑ **DEPRESSION**
- ❑ **DRUG DEPENDENCY**
- ❑ **INSOMNIA**
- ❑ Memory Loss or Confusion
- ❑ **MENTAL ILLNESS**
- ❑ Nervousness

Cardiac
- ❑ Angina Pectoris
- ❑ **ARTERIAL FIB**
- ❑ Chest pain
- ❑ **CONGESTIVE HEART FAILURE**
- ❑ **CORONARY ARTERY DISEASE**
- ❑ **HEART ATTACK**
- ❑ **HEART DISEASE**
- ❑ **HYPERTENSION** (High Blood Pressure)
- ❑ **HYPOTENSION** (Low Blood Pressure)
- ❑ Irregular Heartbeat
- ❑ **MITRAL VALVE PROLAPSE**
- ❑ Swelling of feet, ankles, hands

Cancer
- ❑ **BRAIN CANCER**
- ❑ **BREAST CANCER**
- ❑ **CERVICAL CANCER**
- ❑ **COLON CANCER**
- ❑ **OVARIAN CANCER**
- ❑ **PROSTATE CANCER**
- ❑ **RECTAL CANCER**
- ❑ **SKIN CANCER**
- ❑ **STOMACH CANCER**
- ❑ **THROAT CANCER**
- ❑ **THYROID CANCER**

Gastrointestinal
- ❑ Abdominal Pain
- ❑ **COLON POLYPS**
- ❑ **DUODENAL ULCER**
- ❑ **GASTRIC ULCER**
- ❑ **GERD**
- ❑ Heartburn
- ❑ **HEPATITIS**
- ❑ **HIATAL HERNIA**
- ❑ **LIVER DISEASE**
- ❑ Nausea & Vomiting
- ❑ **ULCERATIVE COLITIS**

Respiratory
- ❑ **ASTHMA**
- ❑ Chronic or Frequent Cough
- ❑ **COPD**
- ❑ **EMPHYSEMA OF LUNG**
- ❑ Pneumonia
- ❑ Shortness of Breath
- ❑ **SLEEP APNEA**
- ❑ **TUBERCULOSIS**

Hematology
- ❑ Abnormal bleeding in your family
- ❑ **ANEMIA**
- ❑ Bleeding or Bruising Tendency
- ❑ **CLOTTING DISORDER**
- ❑ Deep Venous Blood Clots
- ❑ Known HIV/Aids Exposure
- ❑ Phlebitis
- ❑ Slow to heal after cuts
- ❑ Transfusion History

Skin
- ❑ Change In Skin
- ❑ Rash or Itching
- ❑ **VARICOSE VEINS**

Congenital
- ❑ **CLEFT LIP**
- ❑ **CLEFT PLATE**
- ❑ **EAR DEFORMITY**
- ❑ **FACIAL DEFORMITY**
- ❑ **HAND DEFORMITY**
- ❑ **HEMANGIOMA**
- ❑ **SKULL DEFORMITY**

Endocrine
- ❑ **DIABETES TYPE I**
- ❑ **DIABETES TYPE II**
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ **GLANDULAR HORMONE**
- ❑ Heat or Cold Intolerance
- ❑ **HYPERTHYROIDISM**
- ❑ **HYPOTHYROIDISM**

Neurologic
- ❑ Head Injury
- ❑ **MIGRAINE HEADACHE**
- ❑ Numbness & Tingling
- ❑ **PARKINSON'S DISEASE**
- ❑ **RESTLESS LEG SYNDROME**
- ❑ **SEIZURE DISORDER**
- ❑ **STROKE**
- ❑ Transient Ischemic Attack
- ❑ Tremors

Breast
- ❑ Breast Discharge
- ❑ Breast Pain
- ❑ Cancer
- ❑ **FIBROCYSTIC DISEASE**
- ❑ Lump in Breast

Genitourinary
- ❑ Hematuria
- ❑ Incontinence
- ❑ **KIDNEY DISEASE**
- ❑ Kidney Stones
- ❑ Urinary Frequency
- ❑ Urinary Tract Infections
- ❑ Urinary Tract Problem

PRESCRIPTION REFILL POLICY

Request for Prescription Medications need to be called in to our office between 8:30 a.m. and 4:00 p.m. Monday through Friday. All approved prescriptions, except narcotics, will be called into the pharmacy by the end of that business day. Narcotic prescriptions cannot be phoned in and must be picked up in the office. Prescriptions should be taken "AS DIRECTED". Early refills may be denied. NO medications will be refilled after hours, or on weekends.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

I have reviewed the above information with the patient.

Physician/ Provider Signature _____ Date _____