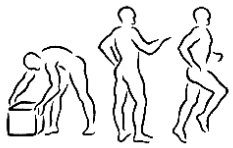
TRIET Q. HUYNH M.D.
ERIC. ALCARAZ D.O.
JACQUELINE AOUGHSTEN ACNP-C
KIMBERLY A. YOUNG FNP-C
Physical Medicine & Rehabilitation
Electrodiagnostic Medicine
Interventional Pain Medicine

CRENSHAW INTERVENTIONAL PAIN SPECIALISTS



Important Notice

Please be aware that your first appointment with Dr. Huynh/Dr. Alcaraz

is for "Consult and Evaluation" only.

Your insurance will be charged for this visit.

Medication may or may not be prescribed.

By signing this notice you are agreeing to proceed with your appointment.

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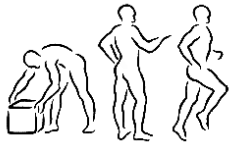

ASSIGNMENT OF BENEFITS

I hereby authorize Dr. Triet Q. Huynh/Dr. Eric Alcaraz to apply for benefits on my behalf for covered services rendered by him or his order.

I hereby authorize and direct you, and/or any insurance carrier involved, to make payments directly to Dr. Triet Q. Huynh/Dr. Eric Alcaraz such sums as may be due and owing to him for medical service(s) rendered to be both by reason of accident/illness and by reason of any other bills that are due in this office.

**** I fully understand that I am directly and fully responsible to Dr. Triet Q. Huynh/Dr. Eric Alcaraz for all bills submitted by them for services rendered to me, and agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.**

I permit a copy of this assignment of benefits to be used in place of the original.

AUTHORIZE FOR RELEASE OF INFORMATION:
I hereby authorize the release of any medical information necessary to process my claims. I permit a copy of the authorization to be used in place of the original.

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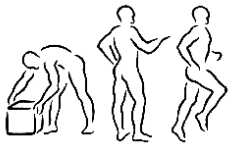

Controlled Substance Agreement
****Please Read****

I agree to participate in the pain management program with Dr. Huynh/Dr. Alcaraz. I am aware that I be provided with controlled substance medication(s) while actively participating in this program only if I adhere to the following rules.

I am aware that if at anytime I do not follow the rules set forth in this agreement that I will be terminated as a patient.

1. **COMPLIANCE:** I will use the controlled substances only as directed by Dr. Huynh/Dr. Alcaraz or his medical staff. I will refrain from using illicit drugs while on these medications. I agree to submit to a blood and urine test at anytime should Dr. Huynh/Dr. Alcaraz request it.

2. **PRESCRIPTION REFILL POLICY:** I will not ask for replacements for lost or stolen medications**. I understand that medication refills can only be given to me during a follow up visit. NO EXCEPTIONS!!!** I understand that it is my responsibility to anticipate the need for a refill and will schedule an appointment in advance. I understand if I do not do so that I may have to go without medications. I will not call and harass the office staff regarding my medication refills.

3. **DIVERSION:** I understand that it is illegal to share my prescription drugs or sell my prescription drugs to other people and agree to take strict precautions to prevent unauthorized access to my medications.

4. **EXCLUSIVE PROVIDER:** I will not receive any controlled substances from any other doctor without notifying Dr. Huynh/Dr. Alcaraz. I agree to inform my other doctors that I am receiving These medications and request they contact Dr. Huynh/Dr. Alcaraz before prescribing any medications that might alter my mood or consciousness.

5. **DETOXIFICATION:** I agree to participate in a detoxification program if requested by Dr. Huynh/Dr. Alcaraz.

6. **SIDE EFFECTS:** I understand that controlled substances may cause a variety of side effects, including but limited to, nausea, vomiting, constipation, dry mouth, difficulty urinating, weight changes, suppressed immune system, altered hormone levels (thyroid & sexual), itching, allergic reactions, imbalances in both blood & chemistry and altered sexual function. I am also aware and understand that

taken improperly, controlled substances may cause excess sedation, depressed breathing and even death, especially if combined with alcohol or other mood or consciousness altering substances. I understand that these medications may alter my ability to drive a car or operate heavy machinery and will comply with all state & federal laws regarding such activities while using these medications.

7. **TOLERANCE, DEPENDENCE AND ADDICTION:** I understand that controlled substances may cause physical dependence and that sudden withdrawal may cause symptoms such as abdominal and muscle cramps, sweats, chills, nausea and vomiting. In rare cases it may cause death. I understand that these drugs must be withdrawn slowly. I understand that I may become tolerant to these drugs and require increasing dose for the same amount of pain relief. I understand that there is a small but real chance that I may become psychologically addicted to these medications.

8. **PREGNANCY:** I understand that controlled substances may have adverse effects on the fetus and that there is a strong likelihood that any baby born to a woman taking controlled substances will probably be physically dependent and could suffer withdrawal symptoms.
   FOR FEMALE PATIENTS: I agree to notify Dr. Huynh/Dr. Alcaraz if I become or intend to become pregnant. If I have not been sterilized or am not postmenopausal, I agree to take reasonable and prudent precautions to ensure that I will not become pregnant while taking these medications.

9. **TERMINATION:** Termination of narcotic drug therapy may be instituted for any violation of this agreement or at the clinical discretion of Dr. Huynh/Dr. Alcaraz. I agree to obtain an alternate source of medical care and controlled substances within 30 days of notification of violation of this agreement or enroll in a detoxification program within this time frame. I will not hold Dr. Huynh/Dr. Alcaraz or his staff liable for any sequelae of discontinuance of controlled substances provided 30 days notification of termination. I will not seek controlled substances from Dr. Huynh/Dr. Alcaraz if I decide to discontinue participation in the pain treatment program.

10. **EARLY REFILLS:** I agree to use my medication only as prescribed and understood that if I use it faster than prescribed I will run out of medication. I agree not to ask for an early refill and understand that I will be without medication for a period of time. **I understand that medication refills can only be given to me during a follow up visit. NO EXCEPTIONS!!!** I understand that it is my responsibility to anticipate the need for a refill and will schedule an appointment 2 weeks in advance. Poor planning on my part does not constitute an emergency/walk in appointment.

I have read and understand all of the above terms. I have had the opportunity to ask questions about these terms and all my questions have been answered to my satisfaction. I agree to abide by the terms and provisions of this agreement and understand that failure to do so will lead to termination of treatment.

By signing this agreement I understand that it is my responsibility to schedule appointments IN ADVANCE for any medication refills. MEDICATION WILL NOT BE GIVEN WITHOUT AN APPOINTMENT.