ISPINE SPORTS MEDICINE/ PAIN MANAGEMENT

Twilight Anesthesia Pain Management Consortium

I understand that my prescriptions must be obtained at the same pharmacy. I agree to notify ISPINE SM/PM /TAPMC if the need arises to change pharmacies. The pharmacy I have selected is listed below.

Pharmacy: _____ Phone: _____

I have received a copy of the office policies for ISPINE SPORTS MEDICINE / PAIN MANAGEMENT / TAPMC.

I have received a copy of the informed controlled substance &treatment agreement for IS PINE SM/PM/ TAPMC.

I have received a copy of the Notice of Privacy Practices for ISPINE SM/PM/TAPMC.

I have read and understand these documents and agree to follow these policies to the best of my ability.
I understand that if I fail to abide by these policies I may be discharged from treatment by ISPINE SPORTS MEDICINE/ PAIN MANAGEMENT/ TAPMC.

Print Name:_____ Date: _____

Patient Signature: _____ Witness: _____

(For Office Staff Only)