Razi Medical Group INC

Internal Medicine, Geriatrics
12740 Hesperia Rd., Ste. B
Victorville, CA 92395
Phone (760) 713-6969/Fax (760) 245-9448

PATIENT REGISTRATION FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability.

Patient Information:

Last Name	First Name	Middle Initial
Street Address	City/State/Zip Code	Social Security Number
Phone Number/Other	Date of Birth	Male or Female
Cell Phone	Email	Marital Status S/M/D/W/DP
Emergency Contact/Phone#	Pharmacy Name & Phone Number	

Employer Information:

Name	Phone Number	Occupation
Address	City/State/Zip	

Referred By: (From whom did you hear about us? Self-referred or another Dr?)

Referred By	Phone #	Address
Primary Care Physician	Phone#	Address

Insurance Information:

Primary Insurance Company			
Street Address	City	State	Zip
Member ID/Policy Number		Group Number	
Secondary Insurance Company			
Street Address	City	State	Zip
Member ID/Policy Number		Group Number	

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security Number	Address	City/State/Zip
Home Number	Employer's Name	Work Number

I request that payment under the medical insurance program be made directly to the provider of service on any unpaid bill for services provider. I further authorize any holder of medical or other information about me to release the Social Security Administration, its carriers of insurance companies, any information needed for this or related Medicare or insurance claim. I permit a copy of this authorization to be used in place of the original. Information needed for this or a related Medicare or insurance claim. Permit a copy of this authorization to be used in place of original.

Signature of Patient or Authorized Representative:	**Date:**

RAZI MEDICAL GROUP INC

ARASH MILANI, MD

CURRENT MEDICATION LIST:

NAME	DOSE	DIRECTIONS

RAZI MEDICAL GROUP INC

ARASH MILANI, MD

ADULT HEALTH HISTORY

Name	Age	D.O.B	Date

HISTORY OF PAST ILLNESS

Have you had?

Measles	No	Yes	Rheumatic Fever	No	Yes
Mumps	No	Yes	Heart Disease	No	Yes
Chickenpox	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Venereal Disease	No	Yes
Stroke	No	Yes	Serious Disease	No	Yes

Ever Hospitalized	No	Yes	Date/Explanation:
Ever had Surgery	No	Yes	Date/Explanation:
Had Broken Bones	No	Yes	Date/Explanation:
Head concussions/injuries	No	Yes	Date/Explanation:

Date of Last Tetanus	
Date of Last Pap Smear	
Date of Last Mammogram	

FAMILY HISTORY

Has anyone in your family ever had?

Cancer	No	Yes	Who?
Diabetes	No	Yes	Who?
Tuberculosis	No	Yes	Who?
Heart Trouble	No	Yes	Who?
High Blood Pressure	No	Yes	Who?
Stroke	No	Yes	Who?
Convulsions	No	Yes	Who?
Suicide	No	Yes	Who?

(continue on back)

ADULT HEALTH HISTORY (continued)

SOCIAL HISTORY/ HISTORIA SOCIAL:

Single[ ] Married[ ] Domestic Partner[ ] Separated[ ] Divorced[ ] Widow[ ]

Alcoholic Beverages: Yes[ ] No [ ] Never[ ] How Much?_____
Tobacco or Cigarettes: Yes[ ] No[ ] Never[ ] How Many?_____
Are you sexually active? Yes[ ] No[ ]

What is your job?_____
Education Level? 1[ ]2[ ]3[ ]4[ ]5[ ]6[ ]7[ ]8[ ]9[ ]10[ ]11[ ]12[ ]
Did you graduate High School? Yes[ ] No[ ]
College: Yes[ ] No[ ] Highest Degree:_____

Ethnic Background: American Indian [ ]Asian[ ] Filipino [ ]Pacific Islander[ ]
Black[ ] Hispanic[ ] White[ ] Prefer not to Answer[ ]

SYSTEMIC REVIEW GENERAL:

Recent weight change? Yes [ ] No[ ]
Have you been in good health most of your life? Yes[ ] No[ ]

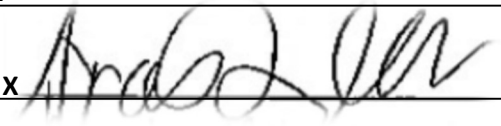
HAVE YOU EVER HAD PROBLEMS WITH?

Skin	YES	NO	Explanation:
Head-Eyes-Ears-Nose-Throat	YES	NO	Explanation:
Neck	YES	NO	Explanation:
Lungs	YES	NO	Explanation:
Heart Circulation	YES	NO	Explanation:
Blood	YES	NO	Explanation:
Emotions	YES	NO	Explanation:
Nerves	YES	NO	Explanation:
Muscles and Bones	YES	NO	Explanation:
Stomach and Bowels	YES	NO	Explanation:
Sex Organs	YES	NO	Explanation:
Urinary	YES	NO	Explanation:
Any Other	YES	NO	Explanation:

Do you have any allergies to reaction to food or medication? Please list all.

_____

Patient Signature : **X** _____ Date: _____

Provider Signature : **X**  Date: _____

RAZI MEDICAL GROUP

ARASH MILANI MD

PATIENT NAME:_____

ADULT TB (Tuberculosis) Risk Assessment

You may be at increased risk for TB if you answer YES to any of the following questions:	Date: / /	Date: / /	Date: / /	Date: / /
1. Do you have a family member or close contact with history of confirmed or suspected TB?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.)	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
3. Do you live in an "out of home" placement facility?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
4. Do you have a history of confirmed or suspected HIV infection?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
5. Do you live with any individual who is HIV positive?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
6. Have you been, or do you live with any individual who has been incarcerated in the last 5 years?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
7. Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

*A person who is at increased risk for TB should have a yearly TB test

Name:_____ Date:_____

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PAIN CONTRACT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

INITIAL all:

_____ • I understand that there is a risk of psychological and/or physical dependence and addiction with chronic use of controlled substances.

_____ • I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____ • I understand that if I break this Agreement provider will stop prescribing these pain control medicines.

_____ • In the case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ • I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ • I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ • I will not use any illegal controlled substances, including marijuana, cocaine, etc. nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ • I will not share my medication with anyone.

_____ • I will note attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ • I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

_____ • I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ • I agree to use this pharmacy_____located at this address_____with telephone number_____for filling my prescriptions for all of my pain medicine.

RAZI MEDICAL GROUP INC

ARASH MILANI, MD

Advance Directives- The Patient's Right to Decide
ACKNOWLEDGEMENT

Physician:_____ Telephone:_____

Address:_____

_____

Patient's Name:_____ DOB:_____

Address:_____ Telephone:_____

_____

Advance Directives-The Patient's Right to Decide

This acknowledgement that the physician or one of his/her staff members, has provided me information concerning Advanced Directives.

8. I am 18 or older. (Circle One) Yes No

9. I realize that I have the options of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is a responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.

10. I am aware that Advanced Directives may be any one of the following:
    a. A Durable Power of Attorney for Healthcare
    b. The Declaration in the A natural Death Act- Ex. A Living Will
    c. I may write down my wished on a piece of pater so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

Patient's Signature: **X** _____ Date:_____

This Document will become part of my medical record.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete the following:

Patient Name_____

Address_____

Date of Birth_____ **SSN**_____ **Phone #**_____

Select one of the following:

☐ **Send Records To:**

_____
Provider/Facility Name

_____ _____
Provider/Facility Phone # Provider/Facility Fax #

☐ **Request Records From:**

_____
Provider/Facility Name

_____ _____
Provider Facility Phone # Provider/Facility Fax #

Records authorized to be released (please select all that apply)

- Any/All medical records
- Lab reports
- Radiology Reports
- Doctor Notes/Progress Notes
- Other_____

By signing this, I am authorizing the named healthcare provider to release my medical information. All medical records take 7 to 10 business days.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient

RAZI MEDICAL GROUP
ARASH MILANI, MD
JORGE SOLER IGLESIAS, NP
CHRISTINE GARRISON, NP
SHEILA KRAFT, NP

Standard Authorization of Use and Disclosure of Protected Health Information

Information pertaining to patient Name:_____
Date of Birth:_____

Information may be disclosed or released by Razi Medical Group. Information to be disclosed includes (please check the authorized information to be released):

- Labs/Imaging Results
- Prescriptions
- Pick up Triplicates (hand written prescriptions) from office
- Appointments
- Medical records

Information may be disclosed or released to:

Name	Relationship
Name	Relationship

This authorization will expire in one year from the date signed, unless you specify a date less than one year from the date signed or unless terminated by the patient or patient's authorized representative. Specify expiration date if less than one year:_____. The patient may revoke or terminate this authorization by submitting a written revocation to Razi Medical Group.
Information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulation.

Patient Signature	Patient representative (if Applicable)
Date	Relationship

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Arash Milani, MD
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Patient Responsibility Form

1. INDIVIDUAL'S FINANCIAL RESPONSIBILTY
    - I understand that I am financially responsible for my health insurance deductible, co-insurance, or non-covered services. Co-payments are due at time of service.
    - If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be 'not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If the insurances submit payment to me for services rendered by **Razi Medical Group INC**. I must forfeit the check for payment of those services to the office.
    - If I am uninsured, I agree to pay for the medical services rendered to me at the time of services.
2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
    - I hereby authorize and direct payment of medical benefits to **Razi Medical Group INC** on my behalf for any services furnished to me by the providers.
3. AUTHORIZATION TO RELEASE RECORDS
    - I hereby authorize **Razi Medical Group INC** to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination as information required for precertification, authorization or referral to other medical providers.
4. MEDICARE REQUEST FOR PAYMENT
    - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished for me by or in **Razi Medical Group INC**.
    - I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____

Print name of Patient, Authorized Representative or Responsible Party

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties' consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If a patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

X_____

Initials

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By :**X** _____ _____

Patient's or Patient Representative's Signature (Date)

By: _____

Physician's or Authorized Representative's Signature

By :**X**_____

Print Patient's Name

RAZI MEDICAL GROUP INC _____

Name of Physician, Medical Group or Association Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical records.

Advance Directives- The patient's Right to Decide

All adult individuals in hospitals, nursing homes and other health care settings have certain rights. For example, you have a right to confidentiality of your personal and medical records and to know what treatment you will receive.

You also have another right. You have the right to fill out a paper known as an "advanced directive". The paper says in advance what kind of treatment you want or do no want under special, serious medical conditions- conditions that would prevent you from telling your doctor how you want to be treated. For example, if you taken to a hospital in a coma, would you want the hospital's medical staff to know your specific wishes about decisions affecting your treatment?

This article answers some questions related to a federal law that took effect in 1991 that requires most hospitals, nursing facilities, hospices, home health care programs and health maintenance organizations (HMO's) to give you information about advance directives and your legal choices in making decisions about medical care. The law is intended to increase your control over medical treatment decisions.

The information in this article can help you make decisions in advance of treatment. Because this is an important matter, however, you may wish to talk to family, close friends and your doctor before deciding whether you want an advance directive.

Finally, it is important to remember that state law differs about legal choices available to individuals for treatment options that can be honored by hospitals and other health care providers and organizations. These health care professionals should have information for you on your state's advance directive law.

What is an Advanced Directive?

Generally, an advanced directive is written statement, which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directives are:

- **Living will**
- **Durable power of Attorney for Health Care**

An advance directive allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive can enable you to make decisions about your future medical treatment. You can say, "yes" to treatment you want, or say "no" to treatment you don't want.

What is a Living Will?

A Living Will generally states the kind of medical care you want (or don't want) if you become unable to make your own decision. It is called a Living Will because it takes effect while you are still living.

Most states have their own living will forms, each somewhat different. It may also be possible to complete and sign a pre-printed living will form available in your own community, draw up your own form, or simply write a statement of your preferences for treatment. You ma also wish to speak to an attorney or your physician to be certain you have completed the living will in a way that your wished will be understood and followed.

What is a Durable Power of Attorney for Health Care?

In many states a Durable Power of Attorney for Health Care is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son, or close friend as your agent or proxy to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Some states have specific laws allowing a health care power of attorney and provide printed forms.

Which is better: A Living Will or a Durable Power of Attorney for Health Care?

In some states, laws may make it better to have one or the other. It may also be possible to have both, or to combine them in a single document that descries treatment choices in a variety of situations (ask your doctor

about these) and names someone (call you agent or proxy) to make decisions for you, should you be unable to make decisions for yourself.

You make revoke this authorization, at any time, in writing except to the extent that your physician or the physician's' practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of you rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information complied in reasonable information that is subject to law that prohibits access to protected health information.

You have the right request a restriction of your protected health information. This means you may ask us not to sue or disclose any part of your protected health information for the purposes of treatment, payment to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to received confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electrically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.
We reserve the right change the terms of this notice and will inform you by mail of nay changes. You have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us, or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaints.
We will not retaliate against you for filing a complaint.

This notice as published and becomes effective on/or before April 14,2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Office in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Patient Name_____ Parent or Guardian Signature_____

Date_____ Witness by_____

If patient refused to sign, check here ☐ Patient Account Number_____

RAZI MEDICAL GROUP
ARASH MILANI, MD

HIPPA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our staff and other outside of our office that are involved in our care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care and a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician had the necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that our relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: we may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use the sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations with out your authorization. These situations include: as Required by Law, Public Health issued as required by law: Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors: Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with requirements of Section 164.500.

Other permitted and Required uses and disclosures will be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

Please initial the following:

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

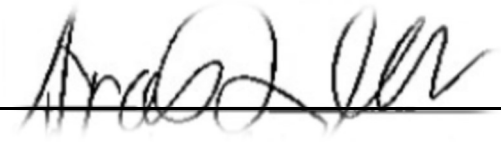
_____I agree that I will use my medicine at a rate no greater than the prescribed rate and that **use of my medicine at a greater rate will result in me being without medication for a period of time.**

_____ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document had been given to me.

This Agreement is entered into on this_____day of _____,20___.

Patient Signature: _____

Patient Name (printed): _____

Provider Signature: 

Provider Name (printed): Arash Milani, MD