Yearly Patient Information Update Form

**THIS FORM MUST BE FILLED OUT NO EXCEPTION**

**\*\* Please provide updated copy of insurance card, photo ID, and pharmacy benefit card. \*\***

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any new medical conditions** **or changes that occurred within the last year :**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­**Please list any new surgeries that occurred within the last year:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any new family medical history that occurred in the last year**:

(ex: father- diabetes) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any family members who passed in the last year:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all drug/food allergies & reaction**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of last routine physical:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Controlled and Opioid Medication Agreement

*The long term use of opioid therapy is somewhat controversial because of uncertainty regarding the extent to which this treatment actually improves the quality of lives of those receiving it. There is the potential risk of development of an addictive disorder or of relapse occurring in a person with a prior addictive disorder. The extent of this risk is not certain. These medications have potential for abuse or diversion and, accordingly, rather strict accountability is necessary when use is prolonged.*

*The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management, as well as other conditions requiring use of controlled substances. This is to help both you and your doctor to comply with laws regarding controlled pharmaceuticals.*

**Please initial the following after reading:**

\_\_\_\_I understand that if I break this agreement, my doctor will stop prescribing these medications. In this case, my doctor will taper me off of the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug- dependence treatment program may be recommended.

\_\_\_\_I will communicate fully with my doctor 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 methamphetamine, cocaine, etc. I also agree to not use alcohol while on controlled medicines due to the potential adverse effects that the combination can cause.

\_\_\_\_I will not share, sell or trade my medications with anyone including my family and friends.

\_\_\_\_I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or ant-anxiety medicines from any other doctor. If controlled medications are given to me through an ER or minor emergency center, a surgeon or other specialist, it is my responsibility to notify Dr. Wolff’s office within 24 hours of receiving these medications.

\_\_\_\_I will safeguard my controlled medicines from loss of theft. Medications will not be replaced if they are lost, fall in the toilet, are eaten by pets, left on an airplane, or for any other reason. I understand that stolen medications will need a police report filed. I agree to notify the doctor within 24 hours of my medication being lost or stolen.

\_\_\_\_I agree that refills of my prescriptions for controlled medicines will be done only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends. I understand that I will need to be seen every 30 days for refills and that no exceptions will be made to the rule.

\_\_\_\_I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state’s Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. 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 doctor to determine my compliance. If my insurance does not cover the expense of these random screenings, I understand that I will be responsible for the cost out of pocket.

\_\_\_\_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 my being without medication for a period of time. I understand that my medicine will not be filled early due to my noncompliance of the prescribed dosing. If I feel that I need to take more medication than I am prescribed. I understand that I need to call and make an appointment to discuss these changes. I understand by not having the approval of the doctor in these changes, I am breaking my agreement.

\_\_\_\_I will bring all unused controlled medicines to every office visit to ensure proper usage.

\_\_\_\_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 has been offered.

\_\_\_\_I understand that there are risks to the long term use of controlled medications and take full responsibly to the use of them.

I agree to use\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pharmacy, located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, for filling prescriptions for all of my controlled medications. If this changes, I will notify Rock Ridge Family Medicine immediately.

This agreement is entered on this \_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Notice of Privacy Practices for Protected Health Information**

Only as otherwise required by law or with your written authorization, you may revoke the authorization as previously provided in this Notice under “Your Health Information Rights”.

I hereby acknowledge that I have received a copy of Rock Ridge Family Medicine’s Notice of Privacy Practices.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Record of Disclosures**

In general, the HIPAA privacy law, give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means; Such as sending correspondence to the individual’s office instead of the individual’s home.

**I wish to be contacted in the following manner (check all that apply):**

Home/Cell phone: \_\_\_Ok to leave message with detailed information

 \_\_\_Leave a message with call back number only

Written Communications: \_\_\_\_ Ok to mail my home address

 \_\_\_\_Ok to mail to my work/office address

 \_\_\_\_Ok to fax to this number

**My insurance information may be discussed with. The following individuals:**

Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My protected health information may be discussed with the following individuals:**

Name and Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Relationships: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_