Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future. We may use or disclose limited amounts of your protected health information to send you fundraising materials. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information for which we would receive compensation would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes" or is for marketing purposes.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPAA and HITECH regulations.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of September 23, 2013.

The Dallas Limb
Restoration Center

Medical History Questionnaire

Patient Name _____ DOB _____ Today's Date _____

Primary Care Provider _____ Height _____ Weight _____

Why are you here today? _____

Patient's Past Surgical History List all surgeries including dental, cosmetic, and elective procedures.

Name of Surgery	Year	Name of Surgery	Year

Have you ever had general anesthesia? ☐ No ☐ Yes Have you ever had conscious sedation? ☐ No ☐ Yes
Have you ever had any problems with any anesthesia or conscious sedation? ☐ No ☐ Yes, describe _____

Family History: Check mark if anyone in your immediate family had or has any of the following disease? If deceased, what age and disease.

	Cancer	Diabetes	Heart Disease	High Blood Pressure	Stroke	Deceased, what age and disease
Mother						
Father						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						
Sibling						
Sibling						

Social History Please check all that apply.
Marital Status: ☐ Single ☐ Married ☐ Other **Stressors:** ☐ Home ☐ Work ☐ Relationship
Employment: ☐ Unemployed ☐ Disabled ☐ Retired ☐ Domestic Engineer/Homemaker ☐ Student ☐ Employed
Substance Abuse / Recreation Drugs: ☐ Denies ☐ Yes, what type: _____ last used _____
Alcohol Consumption: ☐ Denies ☐ Yes: Daily ☐ 1-2 drinks/week ☐ 1-2 drinks/month ☐ 1-2 drinks/year
Smoking / Tobacco: ☐ Denies ☐ Yes _____ packs/day for _____ years ☐ Quit: When _____ ☐ Chew ☐ Dip
Immunizations: ☐ TD less than 10 years ☐ Pneumococcal less than 5 years ☐ Childhood immunization up to date

MEDICATION ALLERGIES:

Medication Name	Reaction	Medication Name	Reaction

CURRENT MEDICATIONS: List all prescription, over the counter, herbal, and vitamins you take.

Name and Dosage	Name and Dosage	Name and Dosage

Signature of Patient _____ Date _____

Name of Person Completing Form: _____ Relation to Patient _____

The Dallas Limb
Restoration Center

Health Questionnaire

Circle the items that you have and/or have had in the past

Childhood Diseases

Measles	yes	no	Mumps	yes	no	Rubella	yes	no
Diphtheria	yes	no	Tetanus	yes	no	Polio	yes	no
Small Pox	yes	no	Rheumatic Fever	yes	no	Whooping Cough	yes	no
Scarlet Fever	yes	no	Chicken Pox	yes	no	Meningitis	yes	no

Neurological

Blackouts	yes	no	Seizures	yes	no	Migraine Headaches	yes	no
Concussions	yes	no	Hit in the Head	yes	no	Lymes Disease	yes	no
Brain Surgery	yes	no	Unconscious	yes	no	Epilepsy	yes	no
Dizziness	yes	no	Stroke/CVA/TIA	yes	no	Difficulty Walking	yes	no
Blurred Vision	yes	no	Double Vision	yes	no	Loss of Bowel/Bladder	yes	no

Cardiovascular

Angina	yes	no	Palpitations	yes	no	Arrhythmia	yes	no
Lightheaded	yes	no	Fainting	yes	no	Bypass Surgery	yes	no
High BP	yes	no	Low BP	yes	no	Anemia	yes	no
Heart Disease	yes	no	Pacemaker	yes	no	AICD	yes	no
Mononucleosis	yes	no	Bleeding Tendency	yes	no	Heart Murmur	yes	no

Respiratory

Hayfever	yes	no	Bronchitis	yes	no	Lung Surgery	yes	no
Allergies	yes	no	Emphysema	yes	no	Pulmonary Edema	yes	no
Asthma	yes	no	Wheezing	yes	no	Pneumonia	yes	no
Short of Breath	yes	no	Pulmonary Embolism	yes	no			
Tuberculosis	yes	no	if yes, date of last ppd _____			or last chest xray _____		

Gastro-Intestinal

Reflux	yes	no	Nausea	yes	no	Persistent Vomiting	yes	no
Hiatal Hernia	yes	no	Chronic Diarrhea	yes	no	Lactose Intolerance	yes	no
Peptic Ulcer	yes	no	Chronic Constipation	yes	no	Vomiting Blood	yes	no

Genito-Urinary

Incontinence	yes	no	Discharge	yes	no	Painful Urination	yes	no
▲ Frequency	yes	no	Bladder Infections	yes	no	Venereal Disease	yes	no
Kidney Disease	yes	no	Bloody Urine	yes	no	Kidney Stones	yes	no

Other Illnesses

▲ Thyroid	yes	no	Cataracts	yes	no	Back Trouble	yes	no
▼ Thyroid	yes	no	Rheumatic Arthritis	yes	no	if yes, when _____		
Osteoarthritis	yes	no	Organ Transplant	yes	no	Unexplained weight gain	yes	no
Cancer	yes	no	Hernia R or L	yes	no	Unexplained rashes	yes	no
if yes, type_____			Blood Transfusion	yes	no	Anxiety	yes	no
Sinus Trouble	yes	no	Unexplained weight loss	yes	no	Blood Clots / DVT	yes	no
Hives	yes	no	Hepatitis A B C D E	yes	no	Liver Problems	yes	no
Eczema	yes	no	Glaucoma	yes	no	if yes, type_____		
AIDS/HIV	yes	no	Poor Blood Circulation	yes	no	Depression	yes	no
Diabetes	yes	no	Atherosclerosis	yes	no			
Difficulty Hearing	yes	no	Hemorrhoids	yes	no	Other: _____		

Type of Birth Control Used_____ Are you claustrophobic? yes no

Explain all yes answers except childhood illness

_____

_____

_____

_____

Patient Name_____ Today's Date _____

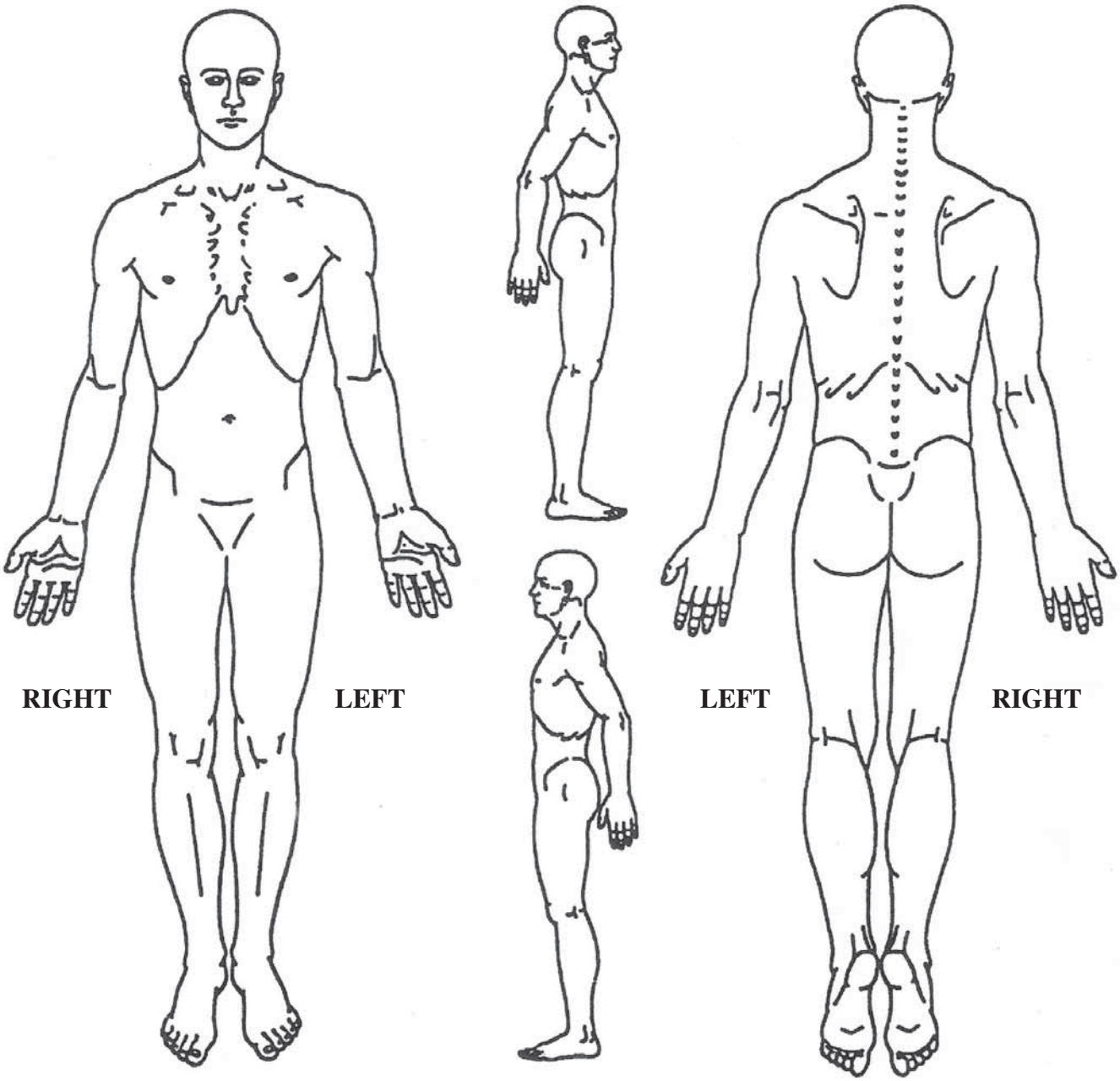
The Dallas Limb
Restoration Center

Where is Your Pain?

Please mark the body image below where you feel the following sensations. Please use the symbols provided.

^^^^^^ **Aches** **** **Numbness** XXXX **Stabbing** ////// **Stabbing** oooo **Pins and Needles**

FRONT **BACK**



RIGHT **LEFT** **LEFT** **RIGHT**

FRONT **BACK**

Patient Name _____ Today's Date _____

HIPAA Information Sheet

WHOM TO CONTACT:

I hereby give permission to The Dallas Limb Restoration Center to disclose and discuss any information related to my medical condition(s) to/with the following family member(s). Other relative(s) and/or close personal friend(s):

Name: _____
Relationship: _____
Phone Number(s): _____

Name: _____
Relationship: _____
Phone Number(s): _____

Name: _____
Relationship: _____
Phone Number(s): _____

☐ I do not wish to give permission for additional family members, relatives and/or close personal friends to have access to any information regarding my medical condition(s).

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Home # _____
Work # _____
Cell # _____

☐ OK to leave message with detailed information at home
☐ OK to leave message with call back number only at home
☐ OK to leave message with detailed information at work
☐ OK to leave message with call back number only at work
☐ Written communication only
☐ OK to send mail to home address
☐ OK to send mail to work/office address at:

_____
_____

☐ OK to fax to this number _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

_____ Date: _____
Signature of Patient or Legal Representative

The Dallas Limb
Restoration Center

History of Present Illness – Pain

Circle those that apply to you.

What caused your illness/pain? Disease Accident/Injury Other _____

Describe how and when the pain started _____

_____

Pain Onset: Sudden Gradual **Is the pain?** Constant Intermittent Occasional

Does the pain radiate/shoots: No Yes Where _____

How many hours per day do you have this pain? _____

Does the pain disturb your sleep? No Yes If yes, how many hours do you get per night? _____

What relieves your pain? Heat Ice Massage Nothing Other _____

What makes your pain worse? _____

What activities are most affected by the pain? _____

Rate your pain below: **(No Pain) 1 2 3 4 5 6 7 8 9 10 (Severe)**

Today it is _____ Average Day _____ Good Day _____ Bad Day _____

What diagnostic tests have you had in the last year? X-ray MRI CT EMG Bone Scan Other _____

What treatments have you received in the last year? Physical Therapy Acupuncture Steroid Injections Manipulation
NSAIDS Steroid Pills Muscle Relaxants Pain Medicine

Have you ever had surgery for this problem? No Yes If yes, when _____

Name of doctor and hospital where surgery was performed? _____

Have you had any previous work related injuries? No Yes, when? _____

Is there a lawyer involved in your case? No Yes, whom? _____

PLEASE COMPLETE THIS SECTION IF YOU WERE INJURED ON THE JOB OR IN AN ACCIDENT

Is this a work related injury? No Yes **Is this an accident/injury?** No Yes

Date of Injury: _____ **When did you first notice the pain?** _____

When and Where did you first seek medical help for this? _____

Are you currently working? No Yes ***See below for further questions***

Yes: Full-time _____ Part-time _____ Regular Duty _____ Light Duty _____ How many hours per day? _____

Describe your duties _____

Sitting ____ hours/day Standing ____ hours/day Lifting ____ hours/day Overhead Reaching ____ hours/day

Climbing ____ hours/day Bending ____ hours/day Pushing/Pulling ____ hours/day Repetitive hand movement ____ hours/day

No: How long have you been out of work? _____ Why did you stop working? _____

Have you tried to return to work? No Yes **Are you currently on disability for this injury?** No Yes

If you were injured in an auto accident, were you the: Driver Passenger

Were you? Rear-ended Side-swiped Broad-sided **Were you wearing a seatbelt?** No Yes

Patient Name _____ Today's Date _____

Disclosure of Ownership

Physicians are required by Texas law (SB 872, 2005) to disclose ownership or financial interest in any health care facilities where their patients may receive medical care. Richard G. Buch M.D., PA and Victor Hakim, M.D., PLLC respect the rights of its patients to choose not only their surgeon but also where they wish to have their surgery done.

Dr. Buch has ownership in Pine Creek Medical Center, Surgery Center of Dallas, Centennial Surgery Center, Cancer Center Strategies Institute, Reliant Rehabilitation Hospital Dallas, and Victory Medical Center at Plano. Dr. Hakim has financial interest at Victory Medical Center at Craig Ranch. These facilities are private, state of the art physician owned and operated. The facilities are owned by many health care providers interested in bettering the health of the community thru a more efficient and personalized delivery of health care. The facilities are fully accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) and by the Centers for Medicare and Medicaid Services (CMS).

Dr. Buch may also have ownership interest in the digital radiography (X-Ray) and MRI equipment used at the facilities. The facilities maintain quality, state of the art diagnostic equipment to quickly and accurately diagnose our patients' injuries and institute treatment programs.

Dr. Buch also has financial interest in CPM Medical, a durable medical equipment company and RxUnlimited Compounding Pharmacy.

We encourage our patients to discuss any concerns they have with us at anytime so that they may make informed decisions regarding their medical care.

I HAVE READ AND UNDERSTAND THE ABOVE DISCLOSURE.

PATIENTS SIGNATURE: _____

DATE: _____

Last Revised 11/18/2013

Authorization for Release of Information and Assignment of Benefits

I hereby authorize The Dallas Limb Restoration Center to furnish information to my insurance carriers and my referring doctors on behalf of myself and/or my dependents; and hereby assign The Dallas Limb Restoration Center all payments for medical services rendered to myself or my dependents. I understand that I am responsible for payment of services as determined by my insurance company. I permit a copy of this authorization to be used in place of the original.

Patient Name: _____

Patient Signature: _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ acknowledge that I have received
(Printed Name of Patient)
a copy of The Dallas Limb Restoration Center "Notice of Privacy Practices". This notice describes how The Dallas Limb Restoration Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Legal Personal Representative) Date

_____

(Relationship to Patient if Applicable)

Acknowledgement of Receipt of Office Policies and Procedures, Including Narcotics Policy

I affirm that I have read and understand the office policies and procedures of The Dallas Limb Restoration Center

_____

(Signature of Patient, or Legal Personal Representative) Date

The Dallas Limb
Restoration Center

Orthopaedic Oncology • Musculoskeletal Tumors • Major Joint Reconstruction

Welcome to our office. Appointments are scheduled by calling our main number. If you are experiencing a medical emergency, call 911. If you are experiencing a problem between appointments, please call and we will decide together if the problem can be handled by phone or visit. We respectfully ask that you schedule separate appointments for each injury or illness. Your cooperation is appreciated.

1. **OFFICE VISIT** - A valid ***CURRENT*** insurance card and photo ID must be available at each office visit. Payment is expected at the time services are rendered. We will help you by filing your insurance for the covered portion. The deductibles and non-covered portions are due at the time of service. For your convenience, we accept cash, check, and credit cards; Visa, American Express, MasterCard. If you are more than ***30 minutes*** late, we may need to reschedule your appointment. Most insurance plans cover 80-100% of your visits. Some insurance policies have deductibles and/or copayments; some do not. ***THIS IS DUE AT CHECK IN.*** If your insurance does not pay its portion within sixty days, you will be called upon to assist in the collection/payment process. Regrettably, it is possible that an appointment may be delayed or rescheduled when accounts are significantly behind. **Initial:** _____

2. **MEDICAL INSURANCE** - Medical insurance plans vary widely in their coverage of services. Your contract is an agreement between you and the insurance company. This contract does not obligate the doctor to charge a specific fee or to accept reimbursement from your insurance company as payment in full, unless the contracted amount is paid on time. You will remain responsible for the uncovered balance. Complaints or inquiries about insurance coverage should be directed to your insurance carrier. **Initial:** _____

   WE DO NOT BILL AUTO INSURANCE OR THIRD PARTY LIABILITY INSURANCE.

3. **PREAUTHORIZATION OF BENEFITS** - In some instances, pre-authorization of benefits is required from your insurance carrier. ***If required it is your responsibility to obtain the pre-authorization***. If you decide to forego the pre-authorization, then you are totally responsible to pay personally at the time of services. Pre-authorization are limited to the dates approved. **Initial:** _____

4. **NO-SHOW POLICY** - We require ***one full business day*** notice to reschedule or cancel an appointment (for example, call Friday morning regarding the following Monday). Our no-show policy fee for a ***broken appointment is $50.00*** for less than 1 (one) business day of notice. We do understand that things beyond your control can occur. If this is the case, please call. **Initial:** _____

5. **COLLECTIONS** - All charges are payable within sixty (60) days. Unpaid accounts force us to raise our fees, and to terminate service for the respective patient. Because of this, we are committed to pursue any unpaid account balances. Unpaid accounts will be referred to a professional collection agency, ***(50% charge added to accounts referred to collections)*** or pursued in the courts; NSF checks must be refunded to us immediately. Fee of $25.00 plus the amount of the check due immediately; payment in cash, money order or cashier's check. If you have a financial problem, special arrangements can be made if notification is given to our office at the earliest possible moment. **Initial:** _____

6. **PRESCRIPTIONS** - All medications, including refills are prescribed based on your current condition. Follow up appointments are scheduled to monitor your conditions. If your last appointment was not kept, refills may not be allowed. Call for prescription refills should be placed to your pharmacy. The pharmacy will fax this request to our office. Prescription requests received after 3:00 pm will not be processed until the next business day. ***We do not fax NEW prescriptions***. Pain medications **WILL NOT** be refilled on weekends, holidays or by our on call providers. Therefore, it is your responsibility to call the pharmacy for refills **24** hours prior to running out of medication. **Initial:** _____

7. **TEST RESULTS** - Diagnostic testing results (MRI, CT, biopsies, etc.) return at different times and may take as long as two weeks. The results are monitored and checked as they arrive. Abnormal results often require prompt attention/action and you will be notified immediately. Otherwise, all results are given to the physician and he will discuss the results with you at your next appointment. ***Unless specifically instructed to do so, please do not call the office for results.*** **Initial:** _____

8. **TELEPHONE CALLS** - Patients sometimes become upset when they call the office and cannot get through to the doctor. Our staff is trained to handle all in-coming telephone calls. This procedure allows us to attend to the patients with a minimum of interruptions. ***PLEASE*** be patient, this is a courtesy that you would want observed if you were the patient in the office at the time. ***REPEATED CALLS for the same reason will not facilitate your call***. Your call will be handled as soon as possible, if not immediately. **Initial:** _____

9. **FORMS, LETTER AND MEDICAL RECORDS** - There is a charge for forms that we must complete, or letters that we write. ***PRE-PAYMENT IS REQUIRED***. Disability forms require 30 days to complete. Medical records require authorization and we strictly adhere to HIPAA rules and regulations. Forms and correspondence completion are payable in advance (physician to physician free service). **Initial:** _____

10. **SURGERY** - If a surgical procedure is necessary, a deposit may be required depending on your insurance plan. If there is an applicable deductible and/or co-insurance due it will be collected ***PRIOR*** to your procedure. It is recommended that you contact your insurance carrier to understand your benefits and what you may or may not be responsible for, especially if surgery is anticipated. **Initial:** _____

We appreciate your cooperation.

REVISED: May, 2012

Patient Signature: _____ Date: _____

ATTENTION

Our office is now filling prescriptions electronically when possible. In an effort to make this a smooth transition, please provide us with your pharmacy information.

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Number: _____

Pharmacy Cross Streets: _____

Patient Signature: _____

NARCOTICS POLICY

IN ORDER TO COMPLY WITH CURRENT STANDARDS OF CARE, RICHARD G. BUCH M.D. AND VICTOR HAKIM, M.D. HAVE A VERY STRICT PROTOCOL ON NARCOTICS. WE FEEL IT IS A SHARED RESPONSIBILITY BETWEEN DOCTOR AND PATIENT TO USE THESE MEDICATIONS BOTH PRUDENTLY AND WISELY. YOU SHOULD KNOW THAT THERE ARE POWERFUL AND AFFORDABLE PAIN-RELIEVING MEDICATIONS AVAILABLE FOR SEVERE LEVELS OF PAIN; HOWEVER, THEY COULD ALSO BE POTENTIALLY ADDICTIVE IF USED IRRESPONSIBLY, EXCESSIVELY OR FOR PROLONGED PERIODS. WE RESERVE THE RIGHT TO REFER YOU TO A PAIN MANAGEMENT SPECIALIST TO PRESCRIBE YOUR PAIN MEDICATIONS WHEN NECESSARY; IF SO, WE WILL CONTINUE TO CARE FOR YOUR ORTHOPEDIC CONDITION. YOU, AS THE PATIENT, WILL BE RESPONSIBLE FOR LOCATING A PAIN MANAGEMENT SPECIALIST WITHIN YOUR INSURANCE NETWORK, IF NEEDED. OUR GUIDELINES ARE AS FOLLOWS:

1. Given the nature of your injury or condition, you should only require these types of pain medications for a certain amount of time, if at all. Every effort on our part will be used to switch you over to non-narcotic pain medications as soon as your pain level permits. Our office, your pharmacy and your insurance company will closely monitor your prescription refills for excessive, abusive or long-term use. If necessary, you will be referred to a pain management specialist; failure to seek care with the pain management specialist when referred could result in possible termination of your care.

2. You must use only one pharmacy for these prescriptions. If you feel that you have good reason and must change pharmacies, you must notify your doctor in advance. All pharmacies involved will be notified of the change. If, at any time, it is discovered that you are using more than one pharmacy for the same medication, you will be referred to a pain management specialist. In some situations, possible termination of care may result.

3. It is your responsibility to call your pharmacy for refill request in a timely manner. Your doctor is not in the office everyday. Therefore, if you require a refill on your prescriptions by a certain day, please make sure your pharmacy faxes a request to us before 3:00 p.m. All prescription refills received before 3:00 p.m. will be addressed that day. Any received after 3:00 p.m. will be addressed the following business day. Refill requests will not be addressed on weekends, holidays or by our on call providers. We regret we cannot make exceptions to this. Multiple phone calls and requests will not expedite your refill; more often than not, it will result in a delay due to excessive filtering of your messages. If you require a refill on your medication, contact your pharmacy. Do not call our office for refills; we must receive the request directly from the pharmacy, as they have information which we need in order to approve a refill request.

4. We ask patients to inform us of their present medications. Please tell us of any new medications that you have received from other physicians at each appointment. It is your responsibility to make sure that any new prescriptions that you receive from other physicians are not similar or the same medications, perhaps by different or generic names, for other painful conditions. We must be kept aware of all medication changes by other physicians, as this can be a potentially dangerous situation. If at any time it is discovered that you are using several different doctors to obtain narcotics, you will immediately be referred to a pain management specialist and immediate termination of care may result.

5. We do not keep pain medications in our office.

6. EARLY REFILLS WILL NOT BE HONORED FOR ANY REASON
   DO NOT LOSE YOUR PRESCRIPTION(S)
   DO NOT LET OTHERS USE YOUR MEDICATIONS FOR ANY REASON
   DO NOT PLACE YOUR MEDICATIONS IN AN UNLABELED CONTAINER

These are highly controlled medications. It is your responsibility to take them only as prescribed and according to directions. It is your responsibility to store them legally, safely and out of reach of others. Your irresponsibility or failure to do so will result in an immediate change to non-narcotic medications, possible referral to a pain management specialist, and possible termination of care.