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SHARING OF INFORMATION FOR PURPOSE OF PAYMENT

_____ I acknowledge that AXBBI, PLLC will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, (Initial) Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_____ I acknowledge that AXBBI, PLLC may communicate with me via US mail, Home/Cell Phone and through patient portal.
(Initial)

PAIN MEDICATION POLICY

At Axis Brain & Back Institute, PLLC, our goal is to address your condition with the most innovative, minimally invasive, and cost-conscious treatments available. When appropriate, providers at Axis Brain & Back Institute, PLLC will prescribe **ONE 30-day supply of pain medication for post-operative pain**. This prescription is given to you after surgery upon discharge from the hospital.

There are federal and state laws, regulations and policies regarding the use and prescribing of controlled substances. Controlled substances are drugs that are subject to statutory control. **If patients experience pain beyond the 30-day post-operative follow-up appointment they will be referred to a pain management provider for continued care**. If the prescription are lost or stolen, they will not be replaced.

By signing below, I agree to the Pain Medication Policy and understand the following:

I. Pain medication is **NOT** prescribed before surgery
II. Pain medication prescribed to me will be **after surgery for post-operative pain**
III. I will only be prescribed **ONE 30-day supply** of pain medication
IV. If prescription is lost or stolen they **will not be replaced**
V. If pain management is needed, Axis Brain & Back Institute, PLLC will refer me to an appropriate pain management provider
VI. If I am under Pain Management, **it is my responsibility to comply** with my pain contract in regards to prescriptions

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient Printed Name