Rochester
BRAIN & SPINE
Group PLLC

Welcome to our practice!

You are scheduled to be seen at _____ am / pm on _____ at:

- **400 Red Creek Drive, Suite 120, Rochester NY 14623**

Please arrive around _____ am / pm to check in.

Please be sure to bring your:

- **Insurance card(s).**
- **Photo ID.**
- **Updated/current medication list.**
- **Any applicable copay.**
- **Completed information packet if it has not already been mailed back to us.**
- **Please be sure to bring the imaging CDs we requested you obtain from _____. Failure to obtain the CDs may result in your appointment being rescheduled.**

Please don't hesitate to call the office with any questions:
585-334-5560
We look forward to seeing you!

As a reminder, children under the age of 18 are <u>NOT</u> allowed in the exam rooms and require supervision at all times in the waiting room. Thank you for your cooperation.

Patient Registration

Please complete the information below to help us best serve you. You are required to bring any insurance information, driver's license or photo ID, as well as a copy of any imaging studies that have been completed. Failure to bring these items to your appointment will result in rescheduling. If this form has been mailed to you please return in enclosed envelope 5 days prior to your visit so your information may be processed.

Patient_____ Sex_____ Birth Date_____
Race_____ Ethnicity _____ Language _____
Home Address _____ City _____ State_____ Zip_____
Home Phone ( ) _____ Cell Phone ( ) _____
Employer _____ Work Phone ( ) _____
Address _____City _____State _____ Zip _____
Emergency Contact _____ Relationship _____Phone ( ) _____
Address_____ City_____ State_____ Zip _____
Primary Care Physician_____ Phone ( ) _____
Address_____ City _____ State _____ Zip _____
*Have you ever had a Workman's Comp Injury? _____ Have you ever been involved in a MVA? _____

***If YES to either of these questions – please fill out information below.**

Insurance Information is needed for ALL Insurance Carriers

(Please complete Primary or Medical insurance information even if this is a MVA or Work Injury)

Primary Health Insurance

Carrier_____ ID Number_____
Carrier Address_____ City _____ State_____ Zip_____
Subscriber Name _____Subscriber Birth Date _____
Address (If different than patient) _____

Secondary Health Insurance

Carrier_____ ID Number_____
Carrier Address_____ City _____State_____ Zip _____
Subscriber Name _____ Subscriber Birth Date _____
Address (If different than patient) _____

Workman's Compensation/ MVA Information

Workman's Comp_____ _____MVA _____ Date of Injury_____
Carrier _____ Policy Number _____
Carrier Address _____ City _____State_____ Zip_____
WCB#_____ Carrier #_____ Case Worker_____
Employer _____ Phone ( ) _____
Address _____ City _____ State _____ Zip_____

Insurance and Treatment Authorization and Assignment

I hereby authorize Dr. Seth Zeidman and/or his associate to provide treatment as well as furnish information regarding my illness and treatment for insurance authorization. I also authorize the above information to my family physician, referring physician, and or any other medical facility as required. The information that I have provided on this form is true. I understand that I am financially responsible for any co-pay, co-insurance, deductible or office visit balance not covered by my insurance carrier/workman's compensation or no fault. I agree to pay said balance in a timely fashion. If a surgical intervention is required, I will contact my insurance carrier for pre-approval and determine what my financial obligation would be, if any.

Signature _____ Date _____

Patient Questionnaire

NAME: _____ DOB: _____ AGE: _____
PRIMARY CARE PHYSICIAN: _____ REFERRING PROVIDER: _____

REASON FOR VISIT (Circle One):
NEUROSURGERY: **DR.ZEIDMAN** PAIN MANAGEMENT: **DR.TAHIR** PHYSICAL MEDICINE: **DR.AMEDURI**

MEDICAL HISTORY: Diabetes Heart Disease High Blood Pressure Asthma
Blood clots or Clotting Disorder Osteoporosis Cancer (type) _____
Other: _____

PREVENTATIVE MEDICINE:
Last Mammogram [date and where was it performed?] _____
Last Pap test [date and where was it performed?] _____

SURGICAL HISTORY (Type, Year, Surgeon): Tonsillectomy Appendectomy Cholecystectomy Other:
_____

PAST SPINAL/NECK/BRAIN SURGERIES (Type, Year, Surgeon):_____
(SPINAL FUSION, LAMINECTOMY, DISCECTOMY, ETC...)

Have you ever had X-rays, Studies and/or Nerve tests of your Brain or Spine? Yes No
*If so what imaging studies, where are they completed and when?
_____

FAMILY HISTORY: *PLEASE LIST WHICH FAMILY MEMBER*
Diabetes Heart Disease Cancer (Type) Hypertension Stroke
Other: _____

Most recent occupation held: _____ CURRENTLY WORKING: YES NO
REASON: Retired Disabled Other Last Date Worked _____

SOCIAL HISTORY
LIVES WITH: Alone Spouse Significant Other Friend Children (#)_____

NICOTINE USE: Current Quit Never Packs Per Day _____ Years _____ Quit/When_____
ALCOHOL: Yes No Former Drinks per Day _____
DRUG USE: Yes No Former Substance _____

DRUG ALLERGIES: YES NO Please list _____
OTHER ALLERGIES: YES NO Please list _____
LATEX ALLERGY: YES NO

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING	PRESCRIBING PHYSICIAN

CONSTITUTIONAL	GASTROINTESTINAL	NEUROLOGICAL
o Fatigue	o Constipation	o Numbness/Tingling
o Fever	o Ulcers and Gastritis	o Seizures
o Chills	o Nausea	o Muscular Weakness
o Night Sweats	o Diarrhea	o Memory Difficulty
o Weight Gain	o Abdominal Pain	o Speech Difficulty
o Weight Loss	o Reflux/Indigestion	o Difficulty Concentrating
o Loss of Appetite	o Incontinence of Stool	o Headaches/Migraines
HEENT	**RESPIRATORY**	**MUSCULOSKELETAL**
o Thyroid Lump	o Shortness of Breath	o Joint Pain
o Difficulty Swallowing	o Chronic Cough	o Back Pain
o Hearing Loss	o Spitting up Blood	o Muscular Weakness
o Ear Pain	o Wheezing	o Weakness in Arms or Legs
o Ringing in Ears	o Bronchitis	o Difficulty with Mobility
o Sinus Pain	o Pneumonia	o Balance Disturbance
ALLERGY/IMMUNOLOGY	**SKIN**	**ENDOCRINE**
o Environmental Allergies	o Rash	o Excessive Sweating
o Food Allergies	o Dryness	o Diabetes (Type 1 or 2)
o Latex	o Skin Lesions	o Abnormal Hair Growth
o Drug Allergies	o Eczema	o Thyroid Disease
CARDIOVASCULAR	**GENITOURINARY**	**PSYCHIATRIC**
o Leg Pain with Walking	o Urgency of Urination	o Anxiety
o Swollen Hand and Feet	o Pain with Urination	o Depression
o High Cholesterol	o Night Time Urination	o Other Psychiatric Disorder
o Chest Pain	o Urinary Tract Infection	o Difficulty Sleeping
o Irregular Heart Beat	o Painful Urination	o Suicidal Thoughts
o Varicose Veins	o Kidney Stones	o Homicidal Thoughts
o Leg Swelling	o Blood in Urine	o Mood Swings
o High Blood Pressure	o Frequency of Urination	
o Irregular Pulse	o Incontinence of Urine	
o Heart Murmur	o Sexual Dysfunction	
EYES	**HEMATOLOGIC**	
o Double Vision	o Bruises: Frequent or Easily	
o Vision Changes	o Cuts That Bleed Easily	
o Cataracts	o Enlarged Lymph Nodes	
o Blurred Vision	o Anemia	
o Glaucoma	o Blood Clots	

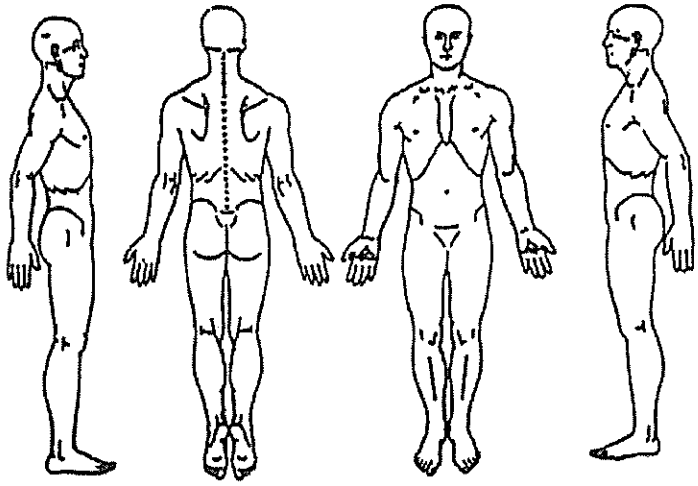
REVIEW OF PAIN

Circle your AVERAGE severity of pain on a scale of 0 (NO pain) to 10 (Severe Pain).
0 1 2 3 4 5 6 7 8 9 10

Describe the type of pain you are experiencing
(Circle all that Apply)

Aching	Cramp
Numbness	Shooting
Stiffness	Throbbing
Burning	Dull
Sharp	Stabbing
Swelling	Tingling

Other:_____



Please shade in the areas where your current pain is located.

What side is your pain on? Left Right Middle

When did it start?

Please describe what happened:

Is it constant or intermittent?

Does anything bring on the pain? _____

Does pain interfere with : Work Sleep Daily Routine Recreation
Other:_____

Does your pain radiate? Right or Left? _____

Activities that exacerbate your pain: Sitting Standing Walking Bending Lying Down
Other:_____

What makes your pain better?_____

Is there anything else you would like to discuss today? _____

Patients Signature: _____ Date: _____

Name: _____ DOB: _____

What conservative treatments have you had in the past?
Please only fill out for the body part you are being seen for today.

CERVICAL, LUMBAR OR THORACIC

Physical Therapy: **Yes** **No**

Where? _____

What dates did you attend? _____

How many total sessions did you attend? _____

Did this make your pain [circle one]: Better Worse No change

Injections: **Yes** **No**

Where and when? _____

What kind of injection did you have? _____

Did this make your pain [circle one]: Better Worse No change

Chiropractic treatment: **Yes** **No**

Where? _____

What dates did you attend Chiropractic treatment? _____

How many total sessions did you attend? _____

Did this make your pain [circle one]: Better Worse No change

HOME EXERCISES: YES NO **Did this make your pain [circle one]:** Better Worse No Change

TENS UNIT: YES NO **Did this make your pain [circle one]:** Better Worse No Change

ACUPUNCTURE: YES NO **Did this make your pain [circle one]:** Better Worse No Change

BRACE: YES NO **Did this make your pain [circle one]:** Better Worse No Change

TRACTION UNIT: YES NO **Did this make your pain [circle one]:** Better Worse No Change

ANTI-INFLAMMATORIES: YES NO **Did this make your pain [circle one]:** Better Worse No Change

Functional Ability Evaluation

Name _____ **DOB** _____

Do you ever use the following (Please circle)

Cane Walker Wheelchair Crutches Brace

Difficulty with

Standing >2 hours	Yes	No	Sitting >2 hours	Yes	No
Walking >2 hours	Yes	No	Stairs	Yes	No
Uneven terrain	Yes	No	Ramps	Yes	No
Getting on Exam Table	Yes	No	Changing Positions	Yes	No

Bladder or Bowel Dysfunction Yes No

Sexual Dysfunction Yes No

Trouble dressing/disrobing Yes No

Daily Living Assistance (Do you need anyone to help you around the house) Yes No

If **YES** then please explain:

Shopping Cooking Cleaning Laundry

Other:

Driving Yes No Limited (explain):

Date Previous Worked:

Frequently miss work because of injury/illness Yes No

If **Yes**, explain:

Working	Yes	No	**Hours/Day:**	**Restrictions:**	
Full time	Yes	No		Yes	No
Part time	Yes	No		Yes	No
Retired	Yes	No	Date Retired: _____		

If any, what are your **restrictions**:

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed: Phone: (585)334-5560 Fax: (585) 334-5603

Rochester Brain and Spine Group 400 Red Creek Drive Suite 120 Rochester, NY 14623

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW _____ DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ STAFF PERSON'S NAME AND TITLE _____ SIGNATURE _____ DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Date: _____

Orientation Agreement

Our goal is to return you to the best level of functioning to allow you to regain control of your life. You, the patient , will actively participate in your treatment regime. The following are a list of polices and commitments that you as a patient need to agree to in order to effectively treat your pain and disability.

1. I understand that it is the patient's responsibility to provide a complete set of medical records including imaging studies (MRI/CT/Xray), notes, lab work, etc to this clinic. This is so I may receive the best possible care.
2. I will be prepared at every visit with a full list of my medications, their dosages, and how often I take them
3. Physicians and Midlevel Providers at ROCHESTER BRAIN AND SPINE will not generally prescribe controlled substances/narcotics for you, however if the provider chooses to prescribe controlled substances to you, there will be an agreement signed between the parties.
    a. If you have already signed an agreement with another provider, signing the agreements will not violate your existing agreement. The provider will not prescribe controlled substances unless it is deemed appropriate to transfer this responsibility to the provider.
4. As a courtesy, the clinic may call to remind me of my appointment the day before, but ultimately it is my responsibility to keep my appointment. If unable to make my scheduled appointment, I will call and cancel (a 48 hour notice is needed). Three missed visits may result in discharge from the practice. I also understand that failure to give proper notification of a cancellation may require me to pay a fine for a missed appointment.
5. Requests for refills must be:
    a. Telephoned to the clinic at least 2-3 days for WC patients and 1-2 days before refill for patients not under WC. If fill date falls on a weekend patients may call the Friday before to request their refill. Be prepared when calling to provide your name, current telephone number, name, and dosage of the medication, how many left and your pharmacy's telephone number.
    b. Refills will not be made at night, on holidays or weekends. Requests are to be made during regular business hours which are noted to be 8:00 a.m. to 4 p.m. Monday through Friday.
    c. Each prescription is expected to last the entire duration of the instructions on the original prescription. If I use up medications earlier than prescribed, I understand that they will NOT be replaced.
    d. It may be necessary that some prescriptions be picked up in person. These prescriptions can only be picked up by the patient or those authorized under that patient's HIPPA form.
    e. If my pain is significantly worsened, I will call the office or go to the emergency room.
    f. I will check all prescription bottles prior to calling the office and have them on hand for any questions that may be asked about my prescription.
6. No prescription refills can be given if I have not been seen in the clinic within the past year. No refills for controlled substance can be given if I have not been seen for three months.
7. I do understand that if I am being treated by the neurosurgery team I will ONLY receive medication during an "acute post operative period." This is defined as 8 weeks post operative from the date of my surgery for any lumbar spine fusions, and 4 weeks post operative from the date of my surgery for any cervical surgery, SCS permanent implantation or lumbar laminectomy. After this period I do understand that my pain medication needs will need to be discussed with my primary physician.
8. Please feel free to call to inform us of any medication problems, however, please realize that in order to provide quality care we may need to see you for a follow-up visit in order to prescribe new medications.
9. I do understand that if I use other pharmacies then what I have declared to the office I will be discharged. I also understand that uses of multiple pharmacies will also result in my discharge from any further medications that are provided form this office and even a discharge from the practice.

10. Due to the nature of pain medicine and the prevalence of illicit drug use in our society, a baseline drug screen may be completed on my first clinic visit (and randomly thereafter). If found positive for illegal drugs, unlisted medications, or misuse of prescribed medications, continuation in the clinic may be dependent upon completion of a drug completions program. I am expected to be honest about any prior history of drug abuse of prescription medicine misuse. I understand that my criminal history may be screened for prior drug charges.
11. In order to prevent insurance misbilling, I will promptly update any charges regarding my demographics or insurance information. Insurance card and ID must be shown at every visit.
12. If I decline access to Sure Scripts – there is a possibility that I may be denied prescriptions through this office.
13. If I use any nicotine product – I am subjected to random nicotine testing/screening per the discretion of the office.
14. If you need dental work and have had a cervical or lumbar fusion, we will prescribe antibiotics for you to take one hour prior to dental work for prophylaxis treatment for one year following surgery.
15. Children under the age of 18 are not allowed in the exam rooms and require supervision at all times in the waiting room.
16. All disability paperwork must be filled out at a formal office appointment. We will only fill out paperwork for patients that we have advised to stop working, and/or provided with an out of work note. We review all paperwork on a case by case basis. We reserve the right to decline filling out paperwork if it is out of our scope of practice. Please reference our disability paperwork policy for further details.

I have read and understand the above information, to the best of my ability. I will adhere to these policies and commitments. I further understand that non-compliance with my treatment program will delay my recovery.

Patient Signature: Date:

PLEASE READ THIS OVER BEFORE APPT AND YOU WILL SIGN STATING YOU READ IT AT THE DAY OF YOUR APPT.

Agreement for Prescribing of Narcotics

The following agreement between the provider and the patient outlines the duties and expectations of each party unless written notice is giving by either party to cancel or amend said agreement.

(Patient's name inserted here) hereafter, referred to as the patient and (providers name inserted here) hereafter, referred to as Doctor, agree that the patient suffers from chronic pain which has not been relieved by other pain control methods and deserves a trial, and possibility long term use of narcotics/opiate medications. The doctor agrees to provide prescriptions for the patient in a medically appropriate manner according to his/her judgement and training as well as what is considered usual and customary practice for speciality of pain management. The goal of narcotic use is not only to decrease pain but also to improve function. The level of function will vary individually. It may be expected for the patient to participate in a functional restoration program including physical and psychological care as prescribed by the doctor. If the patient makes no effort to improve function, the medication may be discontinued. Federal Law requires documenting continued examinations, showing the need for medications, therefore regular office visits are required.

The patient understands that the use of chronic narcotics requires several points of understanding and responsibilities including:

1. TOLERANCE - the need to increase medication dosage to maintain relief, and it is possible that eventually there may be a need to discontinue the medication due to failure to obtain relief at dosages without side effects.

2. PHYSICAL DEPENDANCE - this means the body undergoes changes when exposed to long-term narcotics/opiate use, which may result in a withdrawal syndrome if abruptly discontinued.

3. ADDICTION - this does not apply to the patient simply taking medications regularly for pain relief. However the doctor cannot guarantee that you will not become addicted to your medication. It is possible to start taking them only for psychological effects (such as euphoria) and taking them in a compulsive manner to the detriment of the patient's well-being. Signs of addiction include increasing the dose on your own, seeing multiple prescribing physicians, running out of medication early and getting extra medication from friends and family.

4. OVERDOSE - these medications can cause severe sedation and possibly death from depression of breathing, circulatory failure, or fluid in the lungs.

5. COMMON SIDE EFFECTS - nausea, asthma attacks, impotence, difficulty urinating, confusion, constipation, decreased libido, sedation, swelling, sweating, weight gain and itching.

6. LOSS OF MEDICATION - you must protect against loss, theft, or damage; you must keep them away from children, animals and other persons. Medications will be refilled only at the discretion of the prescribing physician. Also a report should be filed with the insurance company and/or police

department. Repetitive losses may be construed as non-acceptable behavior and result in cessation or discontinuance of medication.

7. BREAKTHROUGH PAIN - does not necessarily mean that your regular medication in not working. Breakthrough pain can occur when physical activity has increased and often a protective response to tell your body to stop overdoing activity. Therefore in general, that type of breakthrough pain is not treated with extra medications. However, there are other types of breakthrough pain that may respond to specifically chosen breakthrough pain medication. If appropriate, you may benefit from a breakthrough pain medication individualized to your condition. Long acting medications such as Oxycontin, Methadone, MS Contin, Kadian, Avinza and Duragesic are NEVER used for breakthrough pain.

8. LACK OF ANALGESIC AFFECT - some pain is not relieved by opiates and the patient may continue to experience pain regardless of the amount of drug taken. If this occurs, the doctor will wean and discontinue the medication and use another form of therapy.

9. FOR MEN - pain medication may lead to less interest in sex and poor sexual performance.

10. FOR PREGNANT WOMEN - pain medication may hurt my unborn child and may cause my child to be born addicted to the pain medication.

Please note: Narcotic/opiate medications may cause drowsiness and sedation in some patients. It is recommended that people taking these medications not operate a motor vehicle or machinery. Also, there may be increased risk of injury in certain occupations that involve the use of machinery or tools. This should be discussed on an individual basis with your doctor.

THE PATIENT THEREFORE AGREES TO THE FOLLOWING:

1. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that may doctor undertakes to treat me based on this agreement.

2. I agree to communicate fully with my doctor about the character and intensity of my pain, the effect of pain on my daily life, and how well the medicine is helping to relieve the pain.

3. To stop all other narcotics, pain medications, and other sedatives unless otherwise directed by the doctor.

4. To take the medication only as directed and call the doctor or the office nurse/PA with any questions to discuss altering the dosage.

5. To utilize only one pharmacy to obtain the medication.

6. To not obtain or seek to obtain any other pain reliever or sedative medication from any other source or physician without first contacting the doctor mentioned above.

7. To keep medication in a secure place, to prevent loss, theft or accidental ingestion by other individuals (children). Lost mediation will not be replaced.

8. To NEVER share the medication with any other individual no matter what the reason.

9. To take the medication in a time contingent manner or as discussed by your physician.

10. To return to see the physician on a regular basis. Pain medications are NOT prescribed to patients who have not been seen within the prior 90 days. Unused medications will be brought in to every office visit.

11. To inform the prescribing physician of any scheduled surgeries or other procedures so that arrangements can be make, if needed, to alter the dosage. An antibiotic will need to be prescribed up to 1 year from having any surgery for any dental procedures, so please call the office before procedures.

12. To notify the office during office hours at least 2-3 days in advance for workers compensation patients and 1-2 days in advance for patients not under workers compensation before running out of medications so that appropriate refills can be made in a timely fashion.

13. To see a psychologist or psychiatrist as directed by the above-mentioned doctor if so requested and follow-up is indicated. I agree to actively participate in all aspects of the pain management program to secure increased function and improve coping with my condition.

14. To notify the pain management physician of any change in my medical condition even if being treated by another physician.

15. I will not hold the physician or any member of Rochester Brain and Spine liable for problems caused by the discontinuance of the controlled substances, provided that I received 30 days notice of termination.

16. I agree to submit to random urine and blood screens to detect the use of non-prescribed medication or illicit drugs at any time, possibly at my own expense.

17. I agree to come in short notice for random pill counts to help assure the medication is not being diverted.

NOTE: 1. No medication refills will be available during after hours, on weekends or on holidays. The office should be notified up to 48 hours in advance before refill is due.

2. No medication will be refilled earlier than 2 days prior to its due date.

3. If the medications are taken in a manner other than prescribed, the doctor reserves the right to refuse to refill a medication.

I agree to use (Patient's name inserted) located at patients address (inserted), telephone number , for filling prescriptions for all my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including New York State's Department of Health, in the investigation of any possible misuse, sale, or other diversion of my pain medication. 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.

Rochester Brain & Spine

Directions to 400 Red Creek Drive, Suite 120, Rochester, NY, 14623

Coming from the North or West:

Take Route 390 South to Exit #13, Hylan Drive
(Note, this is the same exit as Marketplace Mall)
Turn **Left** onto Hylan Drive, Take to End, Calkins Road
Turn **Right** onto Calkins Road
Turn **left** onto Red Creek Drive

Coming from the East:

Take Route 590 South to Route 390 South to Exit #13, Hylan Drive
(Note, this is the same exit as Marketplace Mall)
Turn **Left** onto Hylan Drive, Take to End, Calkins Road
Turn **Right** onto Calkins Road
Turn **left** onto Red Creek Drive

Coming From the South:

Take Route 390 North to exit #13, Hylan Drive
(Note, this is the same exit as Marketplace Mall)
Turn **Right** onto Hylan Drive, Take to End, Calkins Road
Turn **Right** onto Calkins Road
Turn **left** onto Red Creek Drive