Pearl Medical Practice, LLC

Acknowledgment of Office Policy on Chronic Pain & Pain Management

Our office **is NOT a pain Management practice.** However, we prescribe scheduled medications for appropriate treatment and related diagnosis within our practice policy.

Informed Consent for Drug Screen and Payment

I, ____, do hereby voluntarily consent to a drug screen as deemed necessary by my healthcare provider. For this purpose, I consent to the examination of my urine for the presence of drugs.

I further acknowledge that my insurance may not cover the charges associated with Confirmatory testing as required by Pearl Medical's Policy to prescribe controlled substances. The denial reasons are unique to my plan and can vary.

I agree to pay the $85.00 prior to confirmatory testing throughout the time I am receiving a controlled substance. I understand that failure to pay for this testing will result in a discontinuation of prescription pain medication. This testing is to ensure my compliance with the prescribed medication as well as rule out any illicit use that could pose a threat to my health and safety. In lieu of the $85.00 payment,I may also choose to be referred to a pain management specialists for prescribing of controlled substances.

This form has been thoroughly explained to me and all my questions have been answered.

Patient's Signature ____ Date _______________

Witness's Signature ____ Date _______________