

# SUNSHINE SPINE & PAIN, P.A.

**ARKAM REHMAN, M.D.**  
Physical Medicine & Rehabilitation

2021 Kingsley Ave, Suite 103  
Orange Park, FL 32073

14546 St. Augustine Rd, Suite 403  
Jacksonville, FL 32258

PLEASE PRINT PATIENT INFORMATION:

DATE \_\_\_\_\_

NAME \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

SS# \_\_\_\_\_ Last \_\_\_\_\_ first \_\_\_\_\_ middle \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address: \_\_\_\_\_ Home Ph \_\_\_\_\_

Street address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Mailing Address (if Different) \_\_\_\_\_

Place of Employment \_\_\_\_\_

Please Check Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Dependent \_\_\_\_\_

If Married Spouse Name \_\_\_\_\_ Work Number \_\_\_\_\_

Spouse SS# \_\_\_\_\_ DOB: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I give authorization for medical information, lab work results and other test results to be given to the following:  
PATIENT ONLY \_\_\_\_\_ EMERGENCY CONTACT \_\_\_\_\_ OTHER \_\_\_\_\_

**I give authorization for messages to be left on my answering machine for:**

**Test results Or prescription information** \_\_\_\_\_ yes \_\_\_\_\_ No \_\_\_\_\_

Prescription Refill Information:

Pharmacy Name/Location \_\_\_\_\_

Pharmacy Ph# \_\_\_\_\_

## MEDICATION POLICY OF SUNSHINE SPINE & PAIN, P.A.:

It is our goal to provide quality continuity of care for our patients. To do this we need your cooperation. When you need a prescription refill, **please call your pharmacy at least 48 hours in advance** with your request. Your pharmacy will call/ fax us the request with necessary information. This will allow your doctor to review your request and authorize refills after reviewing your medical records. **We request that 48 hrs notice be given to us for refills as we may be unable to honor the same day requests.** No narcotic or other medication refills will be given over the weekends. If your medications are to run out over the weekend, then please call no later than Thursday.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## NO SHOW POLICY OF SUNSHINE SPINE & PAIN, PA:

There is a 24 hour notice required when canceling or rescheduling an appointment. Otherwise, there will be a \$25.00 fee charged for missed office visits and a \$50.00 fee charged for procedures.

PATIENT SIGNATURE \_\_\_\_\_ DATE: ( \_\_\_\_\_

**OPIATE/ NARCOTIC POLICY OF SUNSHINE SPINE:**

NOTE: It is the discretion of the physician as to whether the patient receives any narcotic medications. By signing this contract it does not mean you will be receiving medications however, if the doctor chooses to prescribe narcotic medications you are required to follow all the policies contained below.

It is our mutual understanding that you will not obtain any opiates (narcotics such as morphine, lortab / vicodin, percocet / oxycontin, duragesic etc), muscle relaxers/ or other barbiturate medication from any other physician if you are being treated by us unless its mutually agreed upon.. You will not tamper the medication prescriptions/labels or use fraudulent information regarding obtaining these medications from us. The patient is responsible for safeguarding their medications as we bear no responsibility for lost or stolen medications. If we provide these medications to you, we can, at any time ask you to submit to a urine drug screen. Smoking cessation is strongly recommended as smokers tend not to do well with treatment and medications. Alcohol intake is strictly forbidden when taking these medications as that can result in death. Inappropriate behavior in clinic or with clinic staff on the phone, loss of medications, getting these medications from multiple physicians or failure of a urine drug screen or non submission to it as requested by us will be grounds for discharge from the clinic. I understand the Physical dependence and tolerance phenomenon that may arise out of use of these medications meaning a withdrawal if they are abruptly stopped after a certain dose is used for a time or increasing dosage requirements in future. I understand that addiction is a psychological / behavioral condition where a person may try manipulating the physician or try improper means to obtain and use these medications beyond their prescription directions. A patient depicting addiction behavior will be discharged from the clinic. Referral to addiction clinic can be requested by patient. I also agree to use these medications as prescribed and not over use them. If I or my family feels that I am showing an addictive behavior, I will inform my physician immediately. I have read the above statement and agree with all the provisions of above. If I ask for and use any opiate medications from this clinic, this contract regarding opiate and other medication usage (as described above) will be considered effective and it will be considered that I had ample opportunity to ask questions about these medications.

**I UNDERSTAND THAT SUNSHINE SPINE DOES NOT HAVE ANY NARCOTIC SAMPLES AT ANY LOCATIONS.**

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_