



Patient ID# _____

SIGNATURE SHEET

Initial /Check Below

_____ 1) I have read and agree to Pain Specialists of Greater Chicago Notice of Privacy Practices/ HIPAA policy. Policy #1

_____ 2) I have read and agree to Pain Specialists of Greater Chicago Medication and Prescription/ Refill Policy. Policy #2

_____ 3) I have read and agree to Pain Specialists of Greater Chicago Controlled Substance to Treat Chronic Pain Policy. Policy #3

_____ 4) I have read and agree to Pain Specialists of Greater Chicago Consent to Treat with Opioids Policy. Policy #4

***I will be using the following pharmacy for my prescriptions:**

Pharmacy Name _____ Phone _____

Signature _____ Date _____

Print _____ E-mail Address _____

*Revised 05/06/16, 3/13/17