The SPINE DIAGNOSTIC & PAIN TREATMENT Center

Trusted by doctors for comprehensive pain solutions.

7777 Hennessy Blvd Ste 706, Baton Rouge, LA 70808
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Pain Management Treatment Agreement

The following is an agreement of issues related to treatment of painful disorders through the use of medications and/or controlled substances. Because the medications are potentially dangerous, the side effects and risks are discussed with you at the beginning treatment and periodically thereafter. Opioid medication may cause drowsiness. Alcoholic beverages should be avoided and care should be used when driving/operating dangerous machinery. This facilities goal is to improve their patient's quality of life and the ability to function and/or work. We ask our patients to carefully read, agree and follow the conditions outlined below for the duration of their care at this facility. Non-compliance with any one of these conditions may result in **discharge from the practice.**

I will not ask my doctor to phone in any pain medication for me, as it is against the office's policy. If I need a refill, I will call my doctor 5 days in advance to request. I understand that abrupt discontinuation of these medications may cause severe withdrawal symptoms (e.g. increased pain, agitation, nausea, and diarrhea). I am responsible to make certain I do not run out of my medication on weekends and holidays as the facility will not issue prescriptions after hours.

I will be courteous and respectful to all office staff; this also includes my spouse, family members, etc.

The Spine Diagnostic &Treatment Center must be the ONLY source for the following medications. These medications include, but are not limited to Morphine (MS Contin, Kadian, MSIR); Oxycodone (Percocet, Oxycotin, Roxicodone); Hydromorphone (Dilaudid); Hydrocodone (Vicodin, Lortab, Norco); Propoxyphene (Darvocet); Fentanyl (Duragesic Patch, Actiq); Methadone; codeine (Tylenol No. 3); Benzodiazepines (Valium, Xanax); Stimulants (Adderall, Ritalin); Barbiturates (Fioricet, Fiorinal); etc.

I will not accept any pain medication from any other physician, and I will alert my other physicians of my narcotic treatment with Spine Diagnostic.

I will NOT go to the emergency room for pain management of my chronic condition for which my doctor is currently treating me.

Lost or Stolen prescriptions or medications will NOT be replaced. It is my responsibility to ensure that prescriptions are filled correctly at the pharmacy. If I realize my medication has been lost or stolen, a police report must be filed and the police report with the case number must be submitted to the doctor for possible consideration of a refill of the prescription ONE TIME ONLY.

I will use my pain medication as prescribed, no more than prescribed, nor any modifications to the prescribed dosages (crushing, chewing, tampering, etc.).

I will not give my prescriptions to anyone else. I understand that sharing of my medications is absolutely forbidden and is against the law.

I agree to use ONLY one pharmacy: **Pharmacy Name:______________________________Location:____________________**

If for any reason another pharmacy is used (e.g. unavailability of a medicine), I should notify The Spine Diagnostic & Treatment Center as soon as possible.

I consent for my doctor, his associates, and medical staff to communicate directly with my pharmacy to obtain information regarding my prescription history. I agree to waive any applicable privilege or right of confidentiality with respect to the prescribing of my pain medication. I authorize my pain management physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Louisiana Board of pharmacy, in the investigation of my possible misuse, sale, or diversion of my pain medication. I authorize a copy of this agreement to be provided to my pharmacy and consulting physician.

I agree to adhere to all conditions from my doctor and pharmacy for safe use of my medications.

I understand that I am responsible for picking up my prescription refills personally. However, in the event that I am physically unable to do so, I authorize the facility to issue my prescriptions to the person listed below. I further understand that the authorized person must be 18 years or older. I will advise this person that the facility **WILL NOT** issue the prescription(s) without a picture ID and are expected to sign the statement of receipt.

Name of authorized person: ____

I will keep all scheduled appointments with my doctor unless I give notice of cancellation 24 hours in advance. I understand I may be charged a missed appointment fee for my failure to timely notify the office of my cancellation.

I agree to refrain from all mind/mood altering drugs including alcohol unless authorized by my doctor, and consent to random urine, blood, and hair drug screens as well as random pill count. My failure to comply with this will result in immediate discharge from the practice. I understand that the drug screen results can be given to my other healthcare providers, insurance company, or other reimbursing agencies. I also authorize any other healthcare provider, pharmacy, and law enforcement of judiciary body to release any pertinent information regarding my prescriptions or urine/blood screen results.

Medication therapy usually is only part of the overall treatment plan. I agree to comply with all other treatments as outlined by my physician which may include, but are not limited to physical therapy, exercise, imaging studies (MRI, CT scan, X-ray), psychological counseling/evaluations as ordered. My failure to follow the treatment plan as outlined by my pain management physician suggests that I no longer agree with the treatment plan and may result in my being discharged from the practice.

If I refuse to sign the treatment agreement, I understand that I WILL NOT be treated for pain management at The Spine Diagnostic & Treatment Center.

Termination Clauses

The physician may terminate this agreement at any time if he/she has cause to believe that I am not complying with the terms of this agreement, or that I have made a misrepresentation/false statement concerning my pain or my compliance with the terms of this agreement.

The patient may terminate this agreement at any time.

If this agreement is terminated, the doctor/patient relationship is terminated and the patient will be formally discharged from the facility. Thus, the patient cannot and will not be treated by another physician associated with this practice.

I, the undersigned, attest that the above agreement was discussed with me, and I fully understand and agree to ALL of the conditions, requirements, and instructions. I also understand that failure to comply with the above may result in my discharge from this practice.

Patient Name: ____ (Please Print) Date: ______________________

Patient/Guardian Signature: ____Witness Signature: ___________________

Authorization for Treatment

I hereby authorize the physician(s) of The Spine Diagnostic & Treatment Center to disclose any or all of the information in my records to any person, corporation or agency which is or may be liable for all or part of The Spine Diagnostic and Treatment Center's charge or who may be responsible for determining the necessity , appropriateness, amount or other matter to the health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the social security administration or it's intermediaries or carriers. I understand that my medical records may contain information that indicates that my have a communicable disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning my identity and release The Spine Diagnostic and Treatment Center, its agents and its employees from liability in connection with the release of the information contained therein.

Patient/Guardian Signature: ____

Waiver of Responsibility of Valuables

I hereby release The Spine Diagnostic and Treatment Center from any claim for responsibility of damages in the event of loss of my property, including money and jewelry.

Patient/Guardian Signature: ____

Assignment of Benefits/Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to The Spine Diagnostic and Treatment Center and my assisting physicians for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Patient/Guardian Signature: ____

I agree that a photocopy of this agreement shall be as valid as the original.

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Patient/Guardian Signature

____

Witness Signature

____

Date