Spine Diagnostic & Pain Treatment Center

Treatment Agreement

I, _____ agree to use controlled substances (narcotics, painkillers, sleeping pills, nerve pills) in the treatment of my pain only as prescribed for me by my Spine Diagnostic physician. I know that when I stop the medications, I must do so slowly and under medical supervision in order to prevent withdrawal symptoms. I understand that stopping controlled substances suddenly may result in possible heart attack, seizure, permanent damage, disability, or death.

Please *INITIAL* each item and sign below.

_____ I understand that if I violate any of the terms of this agreement, my treating physician may discharge me from the practice.

_____ I have never been involved in the sale, illegal possession, diversion, or transport of prescribed controlled substances.

_____ I am not currently abusing illicit nonprescription drugs and I am not undergoing treatment for substance dependence or abuse.

_____ I will not misuse or abuse prescribed controlled substances, which means that I agree to take the medication as it was written for me and it will last for the period of time it was written. My medications are not to be shared, given away, or sold. I am not to take anyone else's medication. I will NOT go to the emergency room for pain management of my chronic condition for which my doctor is currently treating me.

_____ I will not obtain or seek controlled substances from any other physician unless approved by the Spine Diagnostic physician. I will disclose to Spine Diagnostic on each visit all physicians, by whom I am being treated, the purpose of the treatment, and the prescriptions, which those physicians have prescribed for me.

_____ 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 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 my consulting physician.

_____ I will not use any other narcotic medication, other controlled substances, or illicit drugs like THC or cocaine and agree to provide a urine specimen upon request for toxicology screening, while under the care of the Spine Diagnostic physician.

_____ I understand that misplaced, lost, or stolen medications or prescriptions will not be replaced and I take responsibility in safe guarding my medication and storing them properly.

_____ 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.

_____ I will arrive in a timely manner for my scheduled appointments. I understand that if I cancel and/or no show more than two scheduled appointments that this is grounds for discharge. In order to have my narcotic medication refilled, in accordance with LA State Law (Act 488), I will need to be seen in an office visit a minimum of every 90 days. A refill may be written for the medication to last a period of no longer than thirty days without a refill.

____ I certify that I am not pregnant, and do not plan to become pregnant. I also certify that I am taking all precautions, which may included use of contraceptives, to prevent my becoming pregnant while undergoing treatment.

_____ I assume responsibility for operating any type of automobile, vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by my physician.

_____ Controlled substances can decrease mental function. I assume responsibility in making any important decisions legal or otherwise while taking controlled substances.

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

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

_____ 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.

_____ 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.

_____ 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.

_____ I agree that all of my protected health information, pursuant to the HIPAA privacy laws, may be disclosed to any of my treating physicians who request it, and may be disclosed to all persons and entities to whom disclosure is allowed by state or federal law. 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.

_____ 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 _____. 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.

Please indicate your pharmacy name _____ and telephone # _____.

I understand that it is **my responsibility, not the pharmacy's**, to call the office (225)769-5554, 72 business hours in advance prior to running out of my medications.

_____ _____ _____

Patient Signature Staff Signature Date

Date of Birth: ____ / ____ / ____ Sex: M ____ F ____ Social Security Number: _____ - ____ - _____

Ethnicity_____ Race _____ Language _____

Responsible Party (if needed): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Alternate Phone: (_____) _____ - _____ Email: _____

Spouse (or responsible party) Name: _____

Spouse Date of Birth: ____ / ____ / ____ Social Security Number: _____ - ____ - _____

In case of emergency, who should be notified?: _____

Phone Number: (_____) _____ - _____

Have you consulted or will you consult with an attorney for this injury? □ Yes □ No

DISCLOSURE OF FINANCIAL INTEREST
As Required by R.S. 37:1744 and
LAC 46:XLV.4211-4215
THE SPINE DIAGNOSTIC CENTER OF BATON ROUGE, INC.
A PROFESSIONAL MEDICAL CORPORATION
5408 Flanders Dr., Baton Rouge 70808
Telephone No. 225-769-5554

The Spine Diagnostic Center of Baton Rouge, Inc. is a voting member of **BETA LAB, L.L.C**. which holds an interest in **Quantum Laboratories, L.L.C.**, located at 3535 S. Sherwood Forest Blvd., Suite 251, Baton Rouge, 70716, which you (or the patient for whom you are the legal representative) are being referred to for clinical laboratory testing. You are not required to utilize this laboratory for these services.