Spine&Nerve
DIAGNOSTIC CENTER

TREATMENT AGREEMENT

We are delighted that you have chosen Spine & Nerve Diagnostic Center for treatment of your pain. Our mission is to help our patients improve their quality of life through an active and independent lifestyle. The following is our Pain Medication/Treatment Agreement. Please review this with your provider who can answer any questions you have about it.

****

I, _____ (Patient Name), understand that I have a right to comprehensive pain management. I wish to enter into a Pain Medication/Treatment Agreement ("Agreement") with Spine & Nerve Diagnostic Center. I understand that my treatment may or may not include the use of prescription pain medication. **I understand that failure to follow this Agreement in any manner may result in Spine & Nerve Diagnostic Center discontinuing prescription drug treatment and/or no longer providing any care to me.** This Agreement is to provide me with information regarding my treatment which may include prescription medications, and to ensure that I and my medical providers are complying with state and federal regulations concerning the taking and prescribing of prescription medications.

I understand that a trial of pain medicine which may include opioids can be considered for moderate to severe pain with the intent of reducing pain and increasing function. Spine & Nerve Diagnostic Center's goal is for me to have the best quality of life possible given the reality of my clinical condition.

I understand that if I have an opioid or prescription medication agreement with another provider or if I am receiving opioids (pain medications) from another provider, Spine & Nerve Diagnostic Center **will not** prescribe opioid medications to me.

(If applicable) The name of the provider prescribing opioids to me is:

_____

Patient Initials:

_____

1. I understand that I have the following responsibilities regarding my treatment:
   a. I will not come to the clinic without an appointment unless it is to pick up paperwork left for me by a provider.
   b. I will treat all Spine & Nerve Diagnostic Center staff and providers with respect and I will refrain from verbally abusive behavior. I understand that if I become abusive or harassing to Spine & Nerve Diagnostic Center staff and/or providers, that I will be discharged.
   c. I will provide 24 hour advance notification if I am unable to keep my appointment. I understand that failure to provide advanced notification or missing two (2) appointments without notification in a six-month period may result in my discharge from Spine & Nerve Diagnostic Center.
   d. I agree to be on time for my appointments. I understand that failure to be timely for appointments may result in my discharge from Spine & Nerve Diagnostic Center.
   e. I will take medications only at the dose and frequency prescribed.
   f. I agree to use one pharmacy for my prescription medications. I will inform Spine & Nerve Diagnostic Center if my pharmacy changes in the future. The name of my pharmacy is:

      _____

   g. I will not increase or change medications without the approval of a Spine & Nerve Diagnostic Center provider.
   h. I will not request opioids or any other pain medicine from physicians or providers other than from Spine & Nerve Diagnostic Center.
   i. I agree to participate in psychiatric or psychological assessments, if necessary.
   j. I understand that I will consent to random drug screening. A drug screening is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. The drug screen helps monitor my compliance with my pain control program.
   k. I will inform the providers at Spine & Nerve Diagnostic Center of all other medications that I am taking.
   l. I will keep my prescription medications in a safe place and away from minors. I understand that lost or stolen medications will not be replaced by Spine & Nerve Diagnostic Center providers.
   m. I will not take illegal, controlled substances such as methamphetamines, cocaine, heroin, etc.
   n. I will not give or sell my prescription medications to anyone.

2. I authorize Spine & Nerve Diagnostic Center to cooperate fully with any City, State or Federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medications. I authorize Spine & Nerve Diagnostic Center to provide a copy of this Agreement to my

Patient Initials:

_____

pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

3. I understand that the providers at Spine & Nerve Diagnostic Center may stop prescribing opioids, change the treatment plan, or discharge me from their care if:

   a. I do not show any improvement in pain from opioids or my physical activity has not improved.
   b. My behavior is inconsistent with the responsibilities outlined in paragraphs 1, 2 and 3 of this Agreement.
   c. I develop rapid tolerance or loss of improvement from the treatment.
   d. If an addiction problem is identified as a result of prescribed treatment of any other addictive substance.

4. I am aware that there are potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. I am also aware about the possible danger associated with the use of opioids while operating heavy equipment or driving. I understand that the following are potential side effects of opioids:

   a. Confusion or other change in thinking abilities.
   b. Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles.
   c. Nausea or vomiting.
   d. Sleepiness or drowsiness.
   e. Constipation.
   f. Worsening of depression.
   g. Dry mouth.
   h. Breathing too slowly – overdose can stop your breathing and lead to death.

5. I understand that the potential side effects as outlined in paragraph 4 above may be made worse if I mix opioids with other drugs, including but not limited to alcohol and benzodiazepines. The following are the risks:

   a. Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
      i. Runny nose; difficulty sleeping for several days; diarrhea; abdominal cramping; sweating; goose bumps; rapid heart rate; and/or nervousness.
   b. Psychological dependence. This means that it is possible that stopping the drug will cause me to miss or crave it.
   c. Tolerance. This means that I may need more and more opioids to get the same effect..

Patient Initials:

_____

d. Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.

e. Problems with pregnancy. If I am pregnant or contemplating pregnancy, I will discuss the use of opioids with my physician and OB/GYN.

I have read this document and have had all my questions answered satisfactorily. I understand that Spine & Nerve Diagnostic Center may terminate this Agreement at any time if there is cause to believe that I am not complying with the terms of this Agreement, or believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this Agreement. I understand that I may terminate this Agreement at any time.

_____ _____

Patient Signature Date

_____

Patient Name Printed

_____ _____

Provider Signature Date

_____

Provider Name Printed