Novus Spine & Pain Center Patient Treatment Agreement and Clinic Guidelines

I understand that Novus Spine & Pain (the "Interventional Pain Clinic") will accept to undertake the management of my pain and other symptoms.

I understand that trust and confidence are necessary in a provider/patient relationship.

I understand that I was given instructions, and provided with phone numbers and directions about how to contact the Interventional Pain Clinic, in case of any questions or concerns regarding my symptoms, medications prescribed by the Interventional Pain Clinic, and side effects that may arise from these medications.

I understand the management of my pain and other symptoms will begin on the date set forth below and continue until I am dismissed or discharged from the Interventional Pain Clinic.

I agree that my physician and/or Interventional Pain Clinic team has evaluated me on an individualized basis and has created a treatment plan for me. I agree that as of this moment, in order to continue receiving care at the Interventional Pain Clinic, I will follow my medication routine and instructions given to me by the Interventional Pain Clinic team, participate in my care, stay respectful towards the staff in my interactions with them, and comply with the following Interventional Pain Clinic Guidelines:

Interventional Pain Clinic Guidelines

- I understand that, except in case of an emergency or hospitalization, I will receive prescriptions for controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications, from one physician only, when possible. If it is not possible to receive my prescriptions for these medications from one physician only, I will receive my prescriptions from another physician at the Interventional Pain Clinic.
- I understand that, except in case of an emergency or hospitalization, I will receive prescriptions for medications from one pharmacy only. If I change my pharmacy, I will notify the Interventional Pain Clinic immediately.

Current pharmacy name and location: ____

Current pharmacy phone: ____

- I will communicate fully and truthfully with my physician about the character and intensity of my pain, the effect of the pain on my daily life and functioning, side effects of medications, and how well the medication is helping to relieve the pain.
- I understand that I am responsible for exhibiting good judgment, and that if I feel mentally impaired while taking medication I will not operate a motor vehicle or heavy equipment, nor will I participate in any activity during which such impairment may endanger another person or property.
- I will communicate fully my personal and family history of substance abuse and mental health problems and/or illness. I may be required to be in active treatment or a recovery program for these problems if my doctor decides it is to my benefit and necessary for continuation of my treatment by the Interventional Pain Clinic.
- I will not use any controlled substance that is not prescribed to me.
- I will destroy or discard medications no longer being prescribed to me from the Interventional Pain Clinic.
- I will not hoard, share, sell, or trade my medication with anyone.
- I will keep my medication out of the reach of children, and will not leave my medication lying around unprotected.
- I understand that rude and disrespectful behavior towards any member of the Interventional Pain Clinic team is not acceptable under any circumstances and may result in my dismissal from the Interventional Pain Clinic.

Patient Initials ________

PATIENT NAME:

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DATE OF BIRTH: ______________________

Pain Clinic Patient Treatment Agreement and Clinic Guidelines

- I will be polite and respectful during my phone conversations with the staff.
- I understand that I am responsible for safeguarding my medication and if it is lost, misplaced or stolen, it may not be replaced. If it is replaced, my insurance company may not provide coverage for the replacement. If it is stolen, a police report may have to be produced in order for me to continue receiving care through the Interventional Pain Clinic.
- I understand that I may be asked to undergo periodic / random, unannounced screening of my urine, saliva, or blood to determine whether I am following the rules of this agreement or have used illegal controlled substances. I will submit to these screenings upon request.
- I will take my medications as only prescribed. I will make no changes to my medication dose and schedule. I understand that unauthorized changes may result in my discharge from the Interventional Pain Clinic.
- I understand that I will need to be seen on a regular basis, as determined by my physician, to continue receiving care. If I am prescribed a controlled substance, I understand that I must be seen by my physician in the clinic monthly. I also understand my physician has a strict policy regarding renewal of my controlled substance medication. Narcotics prescriptions cannot be requested by phone. Medication renewals are not considered an emergency and will not be given or called in on nights, weekends or holidays.
- I may not obtain medications or be seen by the doctor or nurse without a scheduled appointment. No walk-ins are acceptable.
- I understand that my physician may discuss my treatment with pharmacists and other healthcare providers taking care of me, including vendors of medical devices.
- I authorize the Interventional Pain Clinic team members to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any suspected illegal use, diversion, change in prescription, or distribution of my medication. I agree to and hereby waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I understand that:
    - Pain Clinic appointments, rescheduling, and confirmations can be made Monday through Friday from 8 am to 4 pm. All appointment concerns should be called in to 863-583-4445.
    - You must make an appointment and be seen in clinic at least 7 days before my next prescription renewal is due.
    - Medication renewals are contingent on keeping all scheduled appointments and early renewals will not be given.
    - For life-threatening emergencies, I will call 911. For urgencies that occur on weekends, holidays, or nights call clinic during normal business hours or go to local hospital.
- I understand that if my treatment goals are not being achieved, despite medication adjustments, my physician may reevaluate the appropriateness of my continued treatment. My physician may consult with other experts and refer me, as deemed necessary by my physician, for additional evaluation and treatment in order to achieve my goals of care.
- I understand that my failure to adhere to this Patient Treatment Agreement and Interventional Pain Clinic Guidelines may result in more frequent follow-up visits to the Interventional Pain Clinic, refusal of my physician to write a renewal or substitute prescriptions, or discharge/dismissal from the Interventional Pain Clinic.
- I understand that I may release the Interventional Pain Clinic from my care in writing during an Interventional Pain Clinic visit, which will result in my dismissal from the Interventional Pain Clinic. Until then, I will comply with this Patient Treatment Agreement and Interventional Pain Clinic Guidelines.

Patient Initials ______

PATIENT NAME: ______________________

DATE OF BIRTH: ______________________

Interventional Pain Clinic Patient Treatment Agreement and Clinic Guidelines

- I agree that my physician has provided me with, and given me the opportunity to discuss, information concerning pain management and palliative care and my diagnosis, planned course of treatment, alternatives, risks and benefits of pain management, or prognosis for my illness. If I become unable to make my own health care decisions, I agree that this information may be given to my health care surrogate or proxy, court-appointed guardian, or attorney-in-fact under a durable power of attorney, as permitted by federal and state law. I understand that I should contact the Interventional Pain Clinic or my physician with any questions regarding this information.

By signing below I acknowledge that I have read and fully understand this Patient Treatment Agreement and Interventional Pain Clinic Guidelines, that a health care professional has satisfactorily explained the proposed treatment to me, that I have been given the opportunity to ask questions and have had all of my questions answered to my satisfaction, and that I have all of the knowledge I currently desire. I have been given a copy of and agree to comply with this Patient Treatment Agreement and Interventional Pain Clinic Guidelines. I am legally competent and have sufficient knowledge to give voluntary and informed consent and do hereby give my voluntary and informed consent to my treatment set forth in this Interventional Pain Clinic Guidelines and Patient Treatment Agreement.

Printed name of patient: ____

Signature of patient or legal representative: ____________________________ **Time:** _________ **Date:** __________

Witness Signature: ____________________________________ **Time:** __________ **Date:** _________

Printed name of witness: ____

If the patient is determined to be at high risk for medication abuse or has a history of substance abuse, as determined by the physician in his or her clinical judgment, the physician hereby agrees to this Patient Treatment Agreement and Clinical Guidelines.

Physician signature: _______________________________________ **Time:** __________ **Date:** _________

Physician printed name: Benito Torres, DO

PATIENT NAME:

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DATE OF BIRTH: ____________________