PARKWAY
NEUROSCIENCE
& SPINE INSTITUTE

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# TREATMENT AGREEMENT

The purpose of this agreement is to facilitate care and prevent misunderstandings about certain medications between you and your physician at Parkway Neuroscience and Spine Institute. This is to help you and your doctor comply with the laws regarding controlled pharmaceuticals.

I understand that this agreement is essential in the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that 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, chiropractic treatment, imaging studies ( MRI, CT scan, X-ray), psychological counseling/evaluations as ordered, interventional pain management procedures and surgeries as recommended by my physician.

I will be courteous and respectful to all office staff and health providers at all times. Harassing comments or actions towards the office staff, including repeated telephone calls requesting or demanding medications and the use of profanity is cause for discharge from the practice.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the pain medicine is helping to relieve my pain.

I will not attempt to obtain any controlled substances, including marijuana, cocaine, etc. I will not sell, trade, or share my medications with anyone. I will safeguard my medicine from loss or theft. Lost, damaged, or stolen medicines will not be replaced.

I understand the side effects and risks of opiate medications can include nausea, constipation, sleepiness, respiratory depression, intolerance, dependency and addiction.

I agree that refills of my prescriptions for pain medicine will only be made at the time of an office visit or during regular office hours. No refills will be made during evenings or weekends.

I agree to use _____ pharmacy, located at _____, telephone number _____ for filling prescriptions for all of my pain medications.

I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency including the state's Board of Pharmacy, Medicine and Osteopathic Medicine in the investigation of any possible misuse, sale or diversion of my pain medicine. I authorize my doctor to speak to other physicians from whom I receive care regarding this agreement. I authorize my doctor to provide a copy of this agreement to my pharmacy and/or other providers from whom I receive care. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate of no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time and may be grounds for discharge.

I will bring all unused medicine to the office visit upon request. I will not discard unused medications.

I understand that if I break this agreement, my doctor may stop prescribing these pain control medications.

In such a case, my doctor will tape off of the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence treatment program may be recommended.

I understand that violation of any portion of the agreement may result in my being released from the practice and is at the discretion of the providers.

I agree to follow these guidelines and that they have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Printed Name: _____Date of Birth: _____/_____/_____SS#: XXX-XX-_____Date: _____/_____/_____

Signature: _____

Provider Signature: _____