TREATMENT AGREEMENT

ROCKY MOUNTAIN SPINE AND SPORTS MEDICINE ASSOCIATES, LLC
ROCK NAVARKAL, M.D., J.D.

This agreement between _____ (patient) and your provider is for the purpose of establishing an agreement between the provider and patient on clear conditions, which the patient agrees to, in order to participate in the treatment program.

This program may include care from multiple disciplines, including:

1. **Physical Therapy**
2. **Diagnostic and / or therapeutic interventions**
3. **Behavioral medicine** (psychology, psychiatry, coping strategies, biofeedback)
4. **Alternative therapies** (yoga, acupuncture, pilates, massage, etc.)
5. **Use of prescription medications**

The provider and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a provider / patient relationship.

The provider may recommend and / or initiate therapy for your pain condition. An improvement in your function (ability to work, activities of daily living), quality of life and *potentially*, a reduction in the intensity of your pain – are the goals of this programs.

The providers have a strong commitment to furthering knowledge and education in medical treatments. From time to time, your provider may be involved in research studies and may have personnel in training and / or observers present. This may include use of photographs and x-rays or other relevant media, for teaching or research purposes. Your consent will be obtained prior to any such use. Please notify you provider *in writing* if you object to their use. IF you are asked to participate in any research involving experimental protocols that may affect your care, you will be provided a separate informed consent prior to participating in that protocol.

I agree to and accept the following conditions for my treatment program (which may include medications prescribed by the provider(s)); *please initial each statement after reading:*

_____ I agree to keep all scheduled appointment in the clinic. Two or more cancellation with less than 24 hours notice may result in the termination of my treatment. Please note there is a fee charged for no shows and same-day cancellations.

_____ I understand that the **main treatment goals are to *improve my ability to function, ability to work,*** and / or reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following optimal health habits. These include exercise, good nutrition, weight control, avoiding the use of nicotine, no use of alcohol, and proper use of medication. I also agree to comply with the treatment plan as prescribed by my provider. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome from my treatment.

_____ I agree to comply fully with all aspects of my treatment program including behavioral medicine and physical therapy. Failure to do so may lead o re-evaluation of the treatment plan. Te-evaluation may include reduction / alteration of medication. A pattern of repeated inability to comply may result in discharge from care with this clinic.

_____ The provider and I agree that this agreement is important to my provider's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication and / or termination of the provider / patient relationship.

_____ I authorize the provider to provide a copy of this agreement to my pharmacy, other healthcare providers and any Emergency Department upon request. I give my permission to allow sharing of medical history in regards to medication use with other healthcare agencies, unless specifically noted in writing.

TREATMENT AGREEMENT (cont.)

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_____ I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications and I authorize the providers, my pharmacy, and insurers to cooperate fully with any city, state, or federal law enforcement agency ***only*** in the investigation of any possible misuse, sale or other diversion of my pain medication.

_____ **I understand that phone calls after hours should be for issues such as post-procedure complications, significant medication side effects and other urgent matters. For true medical emergencies, "911" should be called and / or Emergency Room treatment should be sought.** For non-emergency matter, the clinic should be called during regular business hours.

_____ I understand that strong medications, which may include opioids (narcotics) and other controlled substances, may be prescribed for pain relief. I understand that there are potential risks and side effects involved with taking any medications, including the risk of physical dependence. Overdose of opioid medication may cause injury or death by stopping the respiratory drive. This may be reversed by emergency personnel if they know opioid painkillers have been taken. It is suggested that I wear a medical alert bracelet or necklace that contains a list of all medications that are being taken. Other possible complications include, but are not limited to, constipation, which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.

_____ I realize that it is my responsibility to keep others and myself from harm. This includes keeping my medication and paper prescriptions in a safe place out of reach of children / people who may search out these types of medications. This also includes the safety of my driving and the operation of heavy machinery. If there is any question of impairment of my ability to safely perform any activity. Has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to ***all*** medication prescribed by your provider.

_____ I realize that ***all*** medications have potential side effects and interactions. I understand and accept that there may be unknown risks associated with the long term use of medications prescribed.

_____ I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependant on the opioids, and withdrawal can be life threatening for a baby. If I am a female of childbearing age, I certify that I am not pregnant and I agree to use appropriate contraceptive measures during the course of treatment with medications from the provider. If I become pregnant during treatment, I agree to immediately notify all my providers, including my primary care physician and / or obstetrician. Some medications could harm the fetus or cause.

_____ I understand I must contact the provider **before** taking **tranquilizers or prescription sleeping medications**. I understand that **the combined use of various drugs,** including opioids and alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, *or even death.*

_____ I understand that opioid analgesics could cause physical dependence within a few weeks of starting continuous opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including cramping, nausea, vomiting, diarrhea, aches, sweats, chills) that may occur 24-48 hours of the last dose. These effects, while uncomfortable, can be managed with medications.

_____ Withdrawal from *other* medications can also have serious consequences, including the risks of injury or death. I agree to not discontinue any medication I take regularly without consulting with the provider or the on-call provider.

TREATMENT AGREEMENT (cont.)

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_____ I agree that continued refill of medication may be contingent upon compliance with the medications as prescribed as well as other treatment modalities recommended by the provider and with the program in general.

_____ Timely requests for refills of medications are the patient's responsibility.

A. Refills may be made **only** during scheduled appointments. **Refills cannot be made over the phone, at night or on weekends. This policy cannot be changed.**
B. Refills may not be made if the patient "runs out early", "loses a prescription", "spills" or "misplaces the medication." The patient is responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining (treat your medication like a valuable piece of jewelry).
C. **Refills may not be made as an "emergency"**. The patient needs to call **at least 48 hours** ahead if they need assistance with a medication prescription.
D. If medications are stolen, and a police report regarding the theft is completed, an exception may be made at the discretion of your provider.

_____ *I agree to use my medication at a rate no greater than the prescribed rate unless it is discussed directly with the provider.*

_____ **I may not use any alcohol or illegal substances** (cocaine, heroin, methamphetamine, etc…) while being treated with controlled substances. The combination of illegal substances and controlled substances may lead to interactions that may cause severe harm or **death.** Violations of this can result in the cessation of the prescribing of any controlled substances and termination of care by you provider.

_____ I may not share, sell, or trade my medication or exchange medication for money, goods or services. Any of these activities may result in immediate termination of care and medication prescriptions.

_____ **I may not alter my medication in any way** (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or inhalation) other than as prescribed by your provider.

_____ I understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is a *felony*. The provider cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.

_____ I agree to discontinue all previously used pain medications unless told to continue them by the provider. I agree to keep the provider informed of **all** medications I may receive from other providers.

_____ I agree to submit to a random blood and / or urine test requested by my provider to determine my compliance with and my regimen of pain control medication. Tests may also include screens for illegal substances.

_____ I may not attempt to get pain medication from any other healthcare provider without telling them that I have already signed this treatment agreement. I agree to inform the other provider to contact this clinic prior to any prescription being written. I also agree to notify this clinic that I had to receive additional pain medications.

_____ I understand that once my pain medication dose is optimized, refill of my medications may be transferred to my primary care provider if possible.

TREATMENT AGREEMENT (cont.)

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_____ I understand that my medication regimen may be continued for a definitive time period as determined by my provider. My case may be reviewed periodically. *If there is not significant evidence that I am improving or that progress is being made to improve / maintain my functioning or quality of life*, the regimen might be tapered or possibly discontinued and my care may be referred back to my primary care provider.

I have thoroughly read, understand and accept all of the above provisions. Any questions I have regarding this agreement have been answered by my provider. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the treatment program INCLUDING Physical Therapy and other appropriate modalities. I also agree to further diagnostic testing if indicated.

Your provider understands that emergencies can occur and under some circumstances exceptions to this agreement may be made. Emergencies are considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your provider in no way invalidates any other provisions of this agreement.

If at any time you are concerned about your medication or side effects of you medication, you may call the provider at (303) 377-7777. The on-call provider can also be contacted to receive your message, if necessary.

I agree to use _____ Pharmacy, located at _____, telephone number: (_____)-_____ for all my pain medications. If I change my pharmacy for any reason, I agree to notify the provider at the time I receive a prescription. I agree to advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on _____(date).

_____
Patient Signature

_____
Witness (optional)