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 three (3) appointments without notification in a one (1) year 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 to me. This also means that I cannot take medications prescribed to anyone other than me.
   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 pharmacy. I agree to waive any applicable privilege or right of privacy or

Patient Initials:

_____

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.

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

Patient Initials: _____

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

6. I understand that Spine & Nerve Diagnostic Center does not allow the use of recording devices anywhere in the clinic and our providers and staff do not consent to being recorded. I will not use any type of recording device while I am in the clinic.

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

Spine&Nerve
DIAGNOSTIC CENTER

Financial Responsibility

For Non-Workers Compensation Patients:

I, _____, understand that I am personally financially responsible for any and all treatment through Spine & Nerve Diagnostic Center. This includes but is not limited to: co-pays, co-insurance and deductibles. Co-pays are due on the date of my visit prior to seeing a provider. I also understand that in the event that my insurance changes or terminates, it is my sole responsibility to notify Spine & Nerve Diagnostic Center prior to the date of my appointment. I understand that if my insurance changes and I have failed to notify Spine & Nerve Diagnostic Center and an authorization is required for an appointment, my appointment will be cancelled and I will be charged a no-show fee.

For Workers Compensation Patients:

I, _____, understand that if my workers compensation case settles or closes in any manner, and I fail to notify Spine & Nerve Diagnostic Center of the settlement or closure and I seek treatment after said settlement or closure, I am personally financially responsible for any and all treatment through Spine & Nerve Diagnostic Center.

Please note that the Spine & Nerve Diagnostic Center Billing Department sends out monthly patient statements for non-workers compensation patients. You may at any time contact the billing department if you have any questions or concerns regarding your insurance, bill or balance. To reach the billing department, please dial the main number for the clinic and listen to the menu option for billing.

Thank you,

Spine & Nerve Diagnostic Center

_____ _____

Patient Signature Date

Spine&Nerve
DIAGNOSTIC CENTER

www.spinenerve.com

Acknowledgement of Receipt of Notice of Privacy Practices, Policies and Procedures

I hereby acknowledge that I reviewed this medical practice's Notice of Privacy in the office or on-line at www.spinenerve.com. I further acknowledge that a coy of the current notice I s available to me at the front desk, and I may request a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____
Signature Date

_____
Print Name

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name and Address of Patient:

_____

_____

_____

I authorized Spine & Nerve Diagnostic Center to share/discuss my personal health information with the following family member or friend:

- ☐ I decline sharing my personal health information with anyone, Or
- ☐ I authorize the following person:

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Please let us know if who we can share your personal health information changes at any point.

Revised 3/30/22

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CANCELLATION AND NO-SHOW POLICY

Office appointments require a minimum of one (1) business day cancellation and procedure appointments require two (2) business days cancellation notice. Without proper notification you will be subject to a no-show fee. Patients who no-show three (3) or more times in a year, may be dismissed from the practice and will be denied any future appointments.

Office Appointments – Minimum one (1) business day cancellation

Procedures (Injections and nerve studies) – Minimum two (2) business days cancellation

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy

_____ _____

Signature Date

_____ _____

Print Name Date of Birth

Revised 3/30/22

FINANCIAL INTEREST DISCLOSURE STATEMENT

Business and Professions Code Section 2426 requires all physicians to report any financial interest in specified health-related facilities held by them or members of their immediate families. The information will be available to other governmental agencies and public and private third-party payors.

Dr. Vinay M. Reddy and Dr. Brian C. Joves are owners of Spine & Nerve Diagnostic Center which is a California Medical Corporation that provides health care services, clinical laboratory services, physical therapy, durable medical equipment, diagnostic imaging and testing, pharmacy services, clinical studies, and spinal injection procedures.

Dr. Vinay M. Reddy, Dr. Brian C. Joves and Dr. Ramandeep Gurai also have ownership interest at Fort Sutter Surgery Center, located at 2801 K Street, Suite 525, Sacramento, CA 95816.

Dr. Brian C. Joves has an ownership interest at Roseville Surgery Center, located at 1420 E. Roseville Parkway, Suite 100, Roseville, CA 95661.

Patient Acknowledgement:

I, _____, (print name of patient or legal representative of patient) hereby acknowledge reading and receipt of a copy of the foregoing Financial Interest Disclosure Statement.

_____ _____

Signature **Date**

NOTICE TO PATIENTS: OPEN PAYMENTS DATABASE
ASSEMBLY BILL (AB) 1278

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Patient Acknowledgement:

_____ _____

Signature **Date**

Electronic Communication Authorization Form

Electronic communication is fast becoming the preferred method of communication for many of our patients. If you would like us to communicate with you via electronic mail or text message regarding recent health updates, changes to policy, advances in medicine, etc., please list your name and e-mail address below. Your privacy is important to us and your electronic address will not be shared with anyone.

Name (Print): _____

Signature: _____

E-Mail Address: _____

Cell Phone Number: _____

NEW PATIENT ACKNOWLEDGEMENT

We are delighted that you have been referred to Spine & Nerve Diagnostic Center for a new patient consult. Our mission is to help our patients improve the quality of their lives through an active and independent lifestyle.

The first visit to our practice is designed to review your medical condition, pinpoint the source of your pain, and collaborate with you on your treatment choices. A key element of our review revolves around your diagnostic studies, such as an MRI and nerve mapping provided by an EMG-Nerve Conduction Study. If these diagnostic studies are either unavailable or over two-years old, we will likely need to help you obtain them.

We will also need to gain a clear understanding of the treatment options you have either tried or are currently using to relieve your pain. It is often as important to know about treatments that have been ineffective as those that have worked well, so please be prepared to discuss these.

Since medications are often used as a central element of treating chronic pain, we will need to evaluate the type and dosage of your current medications, which may include opioids, such as Norco, Vicodin, or Oxycodone. If you are taking an opioid dosage above the levels recommended by the Centers for Disease Control and Prevention,[1] we will counsel you on your alternatives, which may include a referral outside of our practice.

_____ _____

Patient Signature Date

_____

Patient Name (Print)

[1] A full report can be found at www.cdc.gov/HomeandRecreationalSafety/Poisoning/brief.htm