AVALA SPINE

AVALA PAIN

Patient Information

Date:_____

Name:_____ **Please Circle:** Male/Female

Birthdate:_____ Age:_____ Social Security: _____

Home phone:_____ Mobile:_____ Circle: Work/Retired/Disabled/None

Address:_____ City/State:_____ Zip: _____

Email address:_____

Whom may we thank for referring you?_____

Spouse/Guardian:_____ Phone:_____

Emergency Contact: _____ Phone:_____

Relationship:_____

Insurance Company:_____

Policy Holder:_____ Relationship to patient:_____

Birthdate:_____ Social Security:_____

Employer:_____

Policy Number:_____ Group Number:_____

Secondary Insurance Company:_____

Policy Holder:_____ Relationship to patient: _____

Birthdate: _____ Social Security:_____

Employer: _____ Occupation: _____

Policy Number:_____ Group Number:_____

If Medicare is Secondary (Please circle): **Are you or your spouse working?** **Yes/No**
Are you Disabled? **Yes/No**

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Please circle one:

1. **Have you been involved in a motor vehicle accident or suffered an injury of any kind?** Yes/No

If Yes, When? _____

2. **Is this case still in litigation?** Yes/No **Is this case settled?** Yes/No

3. **Do you have an attorney?** Yes/No

If yes, please list your attorney's name and phone number:

_____

_____

Your printed name: _____

Signature: _____

AVALA SPINE

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PATIENT FINANCIAL RESPONSIBILITY POLICY

It is the policy of AVALA Spine to collect co-pays and any outstanding patient balances before each visit. If you cannot pay your co-pay and have any outstanding balance your appointment will be rescheduled.

Our business office will bill your medical insurance for the services rendered in our office. Payment is not guaranteed by your insurance. You are ultimately responsible for all charges. The insurance process normally takes approximately 60- 90 days. You will receive monthly financial statements to include any outstanding charges on your account. Once insurance has processed payment, your financial statement will reflect any deductibles and/or co-insurance due from you as per your insurance.

It is your responsibility to know and understand your insurance policy and benefits. We will bill secondary insurance as a courtesy.

Our providers are not contracted with any AHCCCS / Medicaid insurance programs. You will be responsible for outstanding balances.

If your insurance has lapsed, is inactive, or for any reason does not cover the expenses that you have incurred at AVALA Spine, you will be responsible for the full charges that have been billed to your insurance company. Payment for these charges must be received within 30 days from receipt of your bill.

If you choose to pay by check and your check does not clear, you will be responsible for paying the bank administrative charge of $25.00 plus the amount of your original check.

If we have had no response or contact from you within 60 days to pay off your balance, the Business Office will turn your account over to our collection agency. The collection agency will assess a 20% collection fee due in addition to your original balance.

OUT OF NETWORK POLICY: If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Please Initial: _____

SELF-PAY PATIENT POLICY: We do see patients on a self-pay basis. The charge for services will be collected prior to the service being rendered. Cash, check, debit card with VISA/MasterCard guarantee, or credit card payment is the only accepted form of payment for self-pay patients.

SURGICAL PROCEDURE POLICY: If you become a candidate for injections or surgery, it is our policy to collect any deductible or co-insurance that may be due in advance. Cash, debit card with VISA/MasterCard guarantee, or credit card payment are the only accepted forms of pre-payment for these services. Sorry, no personal checks are accepted. Payment must be received no later than one (1) week prior to surgery or your procedure will be cancelled. To determine any financial responsibility to the facility, please contact the facility prior to your procedure.

DISABILITY/ MEDICAL LEAVE FORM POLICY: If you need a disability / medical leave form filled out there will be a $20.00 charge for each form. By signing this agreement, you understand that you will need to prepay the $20.00 charge for this form to be completed and subsequently released.

CANCELLATION/ NO SHOW POLICY FOR DOCTOR APPOINTMENT: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

Thank you for your understanding of our financial policies at AVALA Spine. If you have any questions, please do not hesitate to give our Business Office a call at 985-400-5778.

_____ _____

Patient Signature Date

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AVALA SPINE ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to DISC of Louisiana, INC., d/b/a "AVALA Spine" as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by AVALA Spine regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize AVALA Spine to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to AVALA Spine any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from AVALA Spine or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feas or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from AVALA Spine. (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by AVALA Spine including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature:_____ Date:_____

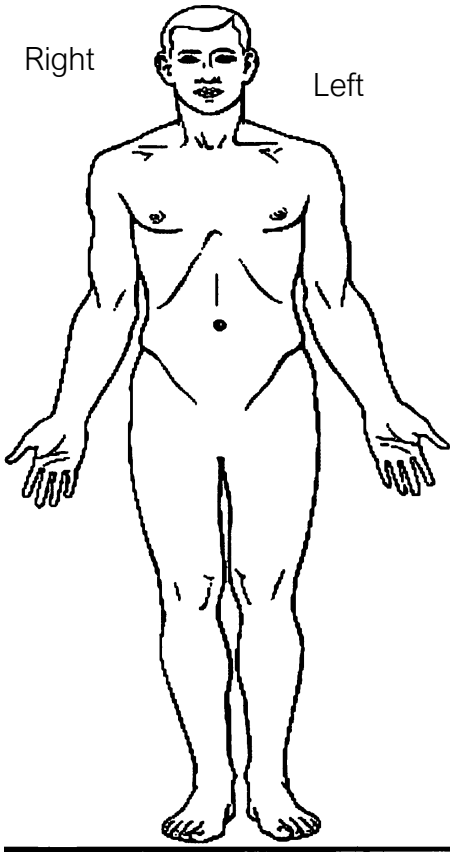
AVALA SPINE

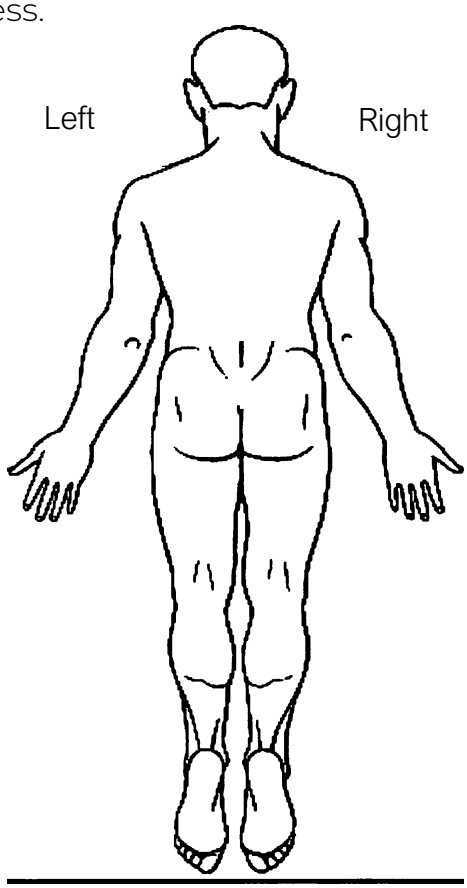
AVALA PAIN

Name:_____

Date:_____

Please mark an "X" on the body part(s) where you have pain, an "0" on the body part(s) where you have numbness.





Select a number to indicate typical level of pain

Neck

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Back

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Right Arm

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Right Leg

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Left Arm

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

Left Leg

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

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Patient Questionnaire/Medical History

Name:_____ **Date:**_____

Birthdate:_____ **Age:**_____ **Height:**_____ **Weight:**_____

History of the problem for which you are seeing us:

Primary Care Physician: _____

Cardiologist: _____ Pulmonologist: _____

When did this problem start? _____

How did it start? ☐ Home/Leisure ☐ At Work ☐ Motor Vehicle ☐ Fall ☐ Other: _____

Location of symptoms/pain? _____

What do the current symptoms/pain feel like?

☐ Aching	☐ Burning	☐ Throbbing
☐ Shooting	☐ Stabbing	☐ Tightness
☐ Tingling	☐ Pressure	☐ Pins and Needles

Frequency of the symptoms/pain? (Please check one)

☐ Constant ☐ Intermittent ☐ Rare

Since you first noticed symptoms have they (Please check one)

☐ Gotten better ☐ Gotten worse ☐ Stayed the same

Does anything make the pain better? _____

Do any of the following activities make your symptoms/pain worse? (please check all that apply)

☐ Walking	☐ Standing	☐ Sitting	☐ Bending
☐ Lifting	☐ Twisting	☐ Working overhead	☐ Pushing
☐ Pulling	☐ Sitting to standing position	☐ Other: _____	

Have you had any new or recurrent problems with: Control of Urination? ☐ Yes ☐ No

Do you have any weakness or numbness? ☐ Yes ☐ No

If so, where? _____

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Name:_____

HISTORY OF TREATMENT OF THIS PROBLEM

Test	Received	Physician	Facility	Date
X-Ray (Brain or Spine)	☐ Yes ☐ No			
MRI Scan (Brain or Spine)	☐ Yes ☐ No			
CT Scan (Brain or Spine)	☐ Yes ☐ No			
EMG	☐ Yes ☐ No			
Other Imaging:	☐ Yes ☐ No			
Pain Management Doctor	☐ Yes ☐ No			
Physical Therapy	☐ Yes ☐ No			
Chiropractor	☐ Yes ☐ No			
Epidural Steroid Injections	☐ Yes ☐ No			
Radiofrequency Ablation	☐ Yes ☐ No			
Nerve Block	☐ Yes ☐ No			
Acupuncture	☐ Yes ☐ No			
Psychiatrist/Psychologist	☐ Yes ☐ No			
Traction	☐ Yes ☐ No			

PAST MEDICAL HISTORY: (Please Check Any/All of the Following that Apply)

☐ AIDS	☐ Diabetes	☐ Hepatitis C	☐ Scoliosis
☐ Anemia	☐ Diverticulosis	☐ High Cholesterol	☐ Seizures
☐ Anxiety Problem	☐ Endometriosis	☐ HIV	☐ Stroke
☐ Arthritis	☐ Enlarged Prostate	☐ Irregular Heartbeat	☐ Thyroid Disease
☐ Asthma	☐ Fibromyalgia	☐ Irritable Bowel Syndrome	☐ Tuberculosis
☐ Bipolar Disease	☐ Gastritis	☐ Kidney Disease	☐ Ulcers
☐ Cancer	☐ Glaucoma	☐ Kidney Stones	☐ DVT/Blood Clot
☐ Colon Polyp	☐ Gout	☐ Liver Disease	☐ Pacemaker
☐ Congestive Heart Disease	☐ Heart Attack	☐ Lupus	☐ Cardiac Loop Recorder
☐ COPD/Emphysema	☐ Heart Disease	☐ Osteoporosis	☐ Pulmonary Embolism
☐ Depression	☐ High Blood Pressure	☐ Peripheral Vascular Disease	

☐ Other:_____

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Name:_____

Past Surgical History

Previous Surgeries	Hospital	Year
☐ Appendectomy		
☐ Cesarean Section		
☐ Gallbladder		
☐ Heart (open/bypass)		
☐ Hysterectomy		
☐ Tonsillectomy		
☐ Other (Please List)		
☐ Spine	☐ Cervical ☐ Thoracic ☐ Lumbar	

Spine Surgeon's name: _____ **Year of surgery:** _____

Social History

Do you smoke? Yes/No Have you smoked in the past? Yes/No

How long have you smoked?_____ # packs a day/brand: _____

Do you drink alcohol? Yes/No How many drinks a month?_____

Do you have a history of drug/alcohol abuse? Yes/No

Have you had your seasonal flu shot? Yes/No

Family History

Please check the box of all of the following problems your blood relatives (i.e. parents, sibling, grandparent) have had:

Illness	Mother/Father	Deceased
☐ Cancer		
☐ Diabetes		
☐ Heart Attack/Heart Disease		
☐ High Blood Pressure		
☐ Mental Illness		
☐ Stroke		
☐ Seizures		
☐ Other		

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Name:_____

REVIEW OF SYSTEMS

Please check any/all you have experienced in the past month. Be sure to notify your doctor if you have experienced any of the following.

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weight Change
- ☐ Blood Clots

Genitourinary
- ☐ Dribbling
- ☐ Bloody Urine
- ☐ STD's (hx)
- ☐ Urinary Incontinence
- ☐ Frequent Urination
- ☐ Urinary Urgency

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Constipation
- ☐ Cramping
- ☐ Diarrhea
- ☐ Painful Swallowing
- ☐ Heartburn/Acid Relief
- ☐ Jaundice
- ☐ Bloody Stool
- ☐ Nausea
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Vomiting
- ☐ Diverticulitis

Eyes
- ☐ Blurry Vision
- ☐ Discharge
- ☐ Burning
- ☐ Pain
- ☐ Redness
- ☐ Dry

ENT/Mouth
- ☐ Ear Drainage
- ☐ Hearing Loss
- ☐ Ear Ringing
- ☐ Bleeding Gums
- ☐ Oral Lesions

Cardiovascular
- ☐ Chest Pain
- ☐ P.N.D.
- ☐ Claudication
- ☐ Murmur
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Valvular Disease
- ☐ Edema
- ☐ Syncope

Endocrine
- ☐ Excess Thirst
- ☐ Frequent Urination
- ☐ Cold Intolerance
- ☐ Heat Intolerance

Any Drug Allergies?_____

Medication History

Pharmacy Name:_____ Phone Number: _____

List the names of ALL medications that you take (including OTC meds), the dosage, and the frequency.

Name of Medication		
1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.
13.	14.	15.
16.	17.	18.
19.	20.	21.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
AVALA Spine - 76 Starbrush Circle, Covington, LA, 70433 – (985) 400-5778

SECTION A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient?

If yes, complete the Authorization for Research form. If no, proceed to Section B.

Section B: Required for all Authorization for Release of PHI or Right of Access

Patient Name:	Birth Date:
Patients Address:	Social Security # (optional)
PHI Recipient Name:	Fax Number:
PHI Sender Name:	Fax Number:

This Authorization will expire on the following: (Fill in the Date or Event, but not both)

Dates:_____ Event:_____

Please check which of the following you would like to be requested.

- ▫ ALL PHI in record
- ▫ History and Physical
- ▫ Consult Report
- ▫ Operative Report
- ▫ Progress Note
- ▫ Physician Orders
- ▫ Laboratory
- ▫ Imaging/Radiology
- ▫ Nursing Notes
- ▫ Medication Record
- ▫ Demographics
- ▫ Rehabilitation Services
- ▫ Special Test/Therapy
- ▫ Itemized Bill/Claims
- ▫ Other

I acknowledge and herby consent to such, that the release information may contain alcohol, drug abuse, psychiatric. HIV testing, HIV results or AIDS information._____(Initial) If not applicable, check here .
I understand that:_____

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

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DESIGNATION OF INDIVIDUAL INVOLVED IN MY CARE

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to authorize the release of your protected health information, including medical and billing records, to an individual(s) you designate. Please complete this form in its entirety designating the individual(s) with whom you would like DIAGNOSTIC AND INTERVENTIONAL SPINAL CARE OF LOUISIANA, INC., D/B/A AVALA Spine to share your information.

Patient Name:_____ Date of Birth: _____

Designation of Individual(s) Involved in My Care:

At my request, I hereby identify the following individual(s):

_____

_____

(Collectively, the "Designated Individual") as an individual(s) involved in my care and I hereby authorize (the "Clinic") to release any and all protected health information about me, including billing and medical records, to the Designated Individual. This authorization permits the disclosure of paper records, electronic records and verbal communications. Additionally, to the extent my medical or billing records contain information related to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, HIV/AIDS, and/or other sensitive information, I hereby agree to its release

Termination/Revocation of Designation: Unless terminated sooner in writing by me, this authorization will terminate three (3) years after my last date of treatment by the Clinic. I understand that I may revoke this authorization and cancel this designation by sending a written Revocation of Designation Form to the clinic at 76 Starbrush Circle, Covington, Louisiana, 70433. I understand and acknowledge that the revocation or cancellation of this designation shall not apply to information that has already been released prior to the revocation/cancellation date.

Re-Disclosure: I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer by protected by HIPAA.

No Obligation to Sign: I understand that I do not have to sign this authorization and treatment of me will not be denied if I do not sign this form. I hereby release and discharge the Clinic, its employees, agents and owners of any liability and will hold them harmless or complying with this authorization.

Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have received a copy
(printed name)
of the Notice of Privacy Practices of **DIAGNOSTIC AND INTERVENTIONAL SPINAL CARE OF LOUISIANA, INC., D/B/A AVALA SPINE.**

_____ _____
Signature Date

_____ _____
Print Name Date of Birth

If not signed by the patient, please indicate relationship:

___Parent or guardian of minor patient

___Power of Attorney, Tutrix, Curator or Designated Personal Representative

_____

(NAME OF PATIENT)

____ ACKNOWLEDGMENT REFUSED:

Efforts to obtain:

_____

_____

Reason for refusal:

_____

_____

AVALA SPINE

AVALA PAIN

PAIN MANAGEMENT TREATMENT AGREEMENT

DATE: _____ **PATIENT FULL NAME:** _____ **DATE OF BIRTH:** _____

The goal of this agreement is to establish and maintain a safe and controlled treatment plan. We strive to make your life as pain-free as possible, so you can return to the activities you enjoy.

BENEFITS

> We provide diagnostic and therapeutic services for pain.
> We apply the latest advances in medicine to relieve pain.
> We strive to improve function and increase quality of life.
> We organize multidisciplinary approaches to manage other issues accompanying pain, if indicated.
> We provide education on the disease of pain, while providing cost-effective care.

OFFICE POLICIES

> I will keep and arrive in a timely manner for my scheduled appointments. No-showing for more than two scheduled appointments or procedures is grounds for patient discharge. I must provide at least **24-hours notice** to cancel an office-visit appointment and at least **48-hours notice** to cancel an appointment for a procedure. A no show fee may be applied if I do not follow the above cancellation guidelines.

> I, and any family members or representatives communicating on my behalf, will be courteous and respectful to all office staff and will not yell, use profanity, or engage in other threatening behavior, whether in person or on the telephone or in other media, when communicating with AVALA Pain staff.

> I understand that when leaving a voicemail, AVALA Pain may require **24 business hours** to return my phone call. Leaving multiple voicemails with the same concern is unnecessary.

PATIENTS RECEIVING OPIOID (NARCOTIC) TREATMENT MUST AGREE AND CONFIRM UNDERSTANDING TO ALL OF THE FOLLOWING STATEMENTS BY SIGNING ON PAGE 3.

POTENTIAL SIDE EFFECTS OF OPIOID/NARCOTIC MEDICATIONS

> While all medications have possible side effects, opioid medications are potentially more dangerous with respect to side effects and/or risks. To ensure safe usage and pain control, proper monitoring through drug testing is required. The following stipulations are mandatory for all patients to receive opioid pain management treatment from AVALA Pain.
> Potential side effects of opioid/narcotic medications include: addiction; appetite decrease or loss; balance and/or coordination disruption; confusion and/or difficulty thinking, concentrating, and focusing clearly; constipation; increased drowsiness/sleepiness; respiratory depression (slowed breathing); psychological dependence; tolerance (needing increased amounts of medication over time).

MEDICATIONS

> I am not and will not be involved in any way in the sale, illegal possession, diversion, or transport of prescribed controlled substances.
> I do not have a problem with substance abuse or medication dependence.
> I will not use illegal substances (Cocaine, Heroin, Meth, Flakka, Ecstasy, LSD, etc.) or drugs not prescribed to me. I will **not abuse** addictive or potentially addictive legal substances (alcohol, marijuana, nicotine, narcotics, prescribed medications, caffeine, etc.).
> I will not use **any** mood-modifying medication, including tranquilizers and medications for ADHD and the like, from **any** other prescriber without first discussing this with my AVALA Pain physician, and I will not abuse such medication.
> **I will obtain all prescriptions for opioids/Narcotics (this includes Medical Marijuana) only from AVALA Pain. I will only take these medications as directed.**
> I will not **share, give, lose, or allow others to consume** my medications. I will not consume medications that haven't been prescribed to me. I understand that AVALA Pain **does not** replace lost or stolen medications.
> I understand that the physicians at AVALA Pain do not write prescriptions for Soma, Xanax, Valium, or Ativan.
> I understand that stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack and seizures.
> I understand that my medication treatment may be discontinued if my AVALA Pain physician feels that opioids are ineffective in relieving my pain or improving my functionality.
> I agree to use **only** one pharmacy to obtain opioid medications. I will notify AVALA Pain immediately if I or my representatives use another pharmacy for any reason.
> I understand that I am required to follow Federal and State guidelines for medication disposal. I will consult with AVALA Pain before **disposing** of any unused medications. AVALA Pain will instruct me how to properly dispose of these unused medications. Medication changes **will not** be made unless I comply with this policy.
> I will be **subject to** random pill counts and random drugs screens and must arrive at the clinic within **24 hours** of a request by AVALA Pain for a pill count or drug test.
> I will not fill a partial prescription. (ex. Filling 7 days of a 30-day prescription) I understand that filling a partial prescription will result in loss of remaining medication. AVALA Pain providers will not provide a new prescription until next scheduled fill date.

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ADDITIONAL TREATMENT

- I will actively participate in other, additional pain therapies as recommended by my AVALA Pain physician. I understand that treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not include prescription strength medication.
- I will participate in a chemical dependency program if my AVALA Pain physician identifies a problem.
- I accept responsibility to gradually increase my daily activities as recommended by my physician.
- I understand that AVALA Pain utilizes Mid-Level providers for follow up office visits.

OTHER MEDICAL CONDITIONS AND OTHER PROVIDERS

- I will immediately notify my AVALA Pain physician if I am or plan to become pregnant.
- I will not obtain or seek controlled substances from any other physicians, including dentists or emergency room physicians. If I receive medical treatment for pain for any reason, I will notify my AVALA Pain physician immediately.
- I will not seek emergency treatment for the pain condition my AVALA Pain physician is treating.
- I will notify any and all of my other providers of my opioid treatment by my AVALA Pain provider. I will not accept any **pain medication** from any other provider.

PATIENT RESPONSIBILITY

- I assume responsibility in making any important decisions, legal or otherwise, while taking controlled substances, as controlled substances can decrease mental function.
- **I assume responsibility for operating any type of automobile, vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by my physician.**

PRESCRIPTION REFILL POLICY

- I understand that opioid prescriptions **are not refilled** without an office visit. Prescriptions for opioid refills are available only through a scheduled visit during regular office hours.
- I take responsibility to plan-ahead, arrive for office visits as scheduled, take my medications as prescribed, and to know when my refills are due to prevent running out of medication prior to my next scheduled appointment.

PATIENT DISCHARGE/TERMINATION FROM CARE OR OPIOID TREATMENT DISCHARGE MIGHT RESULT IF ANY OF THE FOLLOWING OCCURS:

- I refuse or fail to respond to a random pill count or random drug screen by arriving at the clinic within 24 hours of a request by AVALA Pain.
- My AVALA Pain physician feels that opioids or other treatment is ineffective in relieving my pain or improving my functionality.
- I share/give/sell/lose my medications or allow them to be stolen or used by others.
- I fail to take my medications as directed or fail to actively participate in other treatments and programs recommended by my AVALA Pain physician, or otherwise fail to follow my AVALA Pain treatment plan and recommendations.
- I abuse other substances, legal or illegal (alcohol, cocaine, marijuana, narcotics, etc.), or take mood-altering medications not discussed and approved by my AVALA Pain physician.
- I obtain opioid medications from multiple pharmacies, and as prescribed by my AVALA Pain physician.
- I or my representative yell, use profanity, or engage in other threatening behavior or communications with AVALA Pain staff.
- My AVALA Pain physician believes I have falsely stated my compliance with this agreement or that I am not complying with the terms of this agreement.
- I terminate this agreement at any time.
- If this agreement is terminated, the patient/physician relationship will end on the date I terminate the agreement, or the date stated in AVALA Pain's notice of termination. AVALA Pain's notice will provide me with a written explanation of why the discharge occurred, a list of referral resources to find a new physician, and instructions for transfer of records to a new physician. During the notice period, AVALA Pain will provide emergency treatment for the condition then under treatment by AVALA Pain.
- If I am discharged, I cannot and will not be treated by another physician associated with AVALA Pain.

I, the undersigned, attest that I have been informed, fully understand, and have had the opportunity to ask any questions about my Pain Management Treatment Agreement. I agree to all of the conditions and requirements, and I understand that failure to comply with the Treatment Agreement, as outlined by my AVALA Pain physician, indicates I no longer agree with it, which may result in my discharge from this practice.

PATIENT/GUARDIAN SIGNATURE: _____ **WITNESS SIGNATURE:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____