

TREATMENT AGREEMENT

We are pleased that you have chosen Spine & Nerve Diagnostic Center ("Spine & Nerve") for your care. Our goal is to help improve your function, quality of life, and ability to remain active and independent. This Treatment Agreement explains important expectations regarding your care. Your treatment may include medications, physical or rehabilitative treatment, diagnostic testing, injections or other procedures, behavioral health treatment, referrals, or other appropriate therapies. Prescription pain medication, including opioids or other controlled substances, may or may not be part of your treatment.

Patient Name: _____

1. MY TREATMENT

- My evaluation may include review of my medical history, current medications, prior treatments, diagnostic studies, and available treatment options.
- I understand that referral to Spine & Nerve does not guarantee that I will receive any particular medication, diagnostic study, injection, procedure, or other treatment.
- Treatment recommendations will be based on my individual condition, expected benefits and risks, medical necessity, and the clinical judgment of my provider.
- When medications are used to treat pain, the goal is not necessarily to eliminate all pain. Treatment is intended to improve my ability to function and my quality of life while reducing pain when reasonably achievable.
- Continued treatment with a particular medication depends upon whether my provider believes that its benefits continue to outweigh its risks.
- I agree to participate in reasonable components of my treatment plan, which may include physical therapy, exercise, behavioral or psychological treatment, diagnostic testing, specialist evaluation, procedures, or other therapies when clinically appropriate.

2. APPOINTMENTS AND CONDUCT

- I will attend scheduled appointments and make reasonable efforts to arrive on time.
- If I cannot attend an appointment, I will follow Spine & Nerve's current Cancellation and No-Show Policy.
- I understand that repeated missed appointments or failure to participate in necessary follow-up may interfere with safe treatment and may result in modification of my treatment plan.
- I will treat Spine & Nerve providers, staff, and other patients respectfully. Threatening, abusive, harassing, discriminatory, or violent behavior will not be tolerated and may result in termination of the physician-patient relationship when appropriate and permitted by law.
- I will not use audio, video, photographic, or other recording devices in the clinic without prior authorization.

3. MEDICATION INFORMATION

- I will provide Spine & Nerve with complete and accurate information regarding all medications and substances I use, including prescription medications, over-the-counter medications, supplements, alcohol, and other substances when relevant to my care.
- I will promptly inform my provider of significant medication changes made by another treating clinician.
- I understand that medication interactions can cause serious adverse effects and that accurate medication information is important for my safety.

4. IF SPINE & NERVE PRESCRIBES CONTROLLED PAIN MEDICATIONS

If Spine & Nerve prescribes opioids or other controlled pain medications for me, I agree to the following:

Taking Medication Safely

- I will take my medication only as prescribed and will not change the dose, frequency, or manner in which I take it without approval from my Spine & Nerve provider.
- I will not take medication prescribed to another person.
- I will not share, sell, trade, or otherwise provide my medication to anyone else.
- I will not intentionally obtain controlled pain medications from multiple prescribers without appropriate coordination of care.
- I understand that early refills are not guaranteed.
- I understand that lost, stolen, damaged, or misplaced controlled medications generally will not be replaced.

Prescribers and Pharmacy

- Unless otherwise agreed upon with my Spine & Nerve provider, Spine & Nerve will serve as the primary prescriber of controlled medications used for my chronic pain.
- I agree to use one pharmacy for controlled pain medications whenever reasonably possible.

Preferred Pharmacy: _____

- If my pharmacy changes, I will notify Spine & Nerve.

Pt initials: _____

- I understand that my providers may review California's prescription drug monitoring program, including CURES, and other available prescription records as part of safe medication management.

Treatment by Other Clinicians

- If another clinician believes I need controlled pain medication because of surgery, dental treatment, hospitalization, emergency care, or another acute medical condition, I will inform that clinician that I am receiving pain treatment from Spine & Nerve.
- I will notify Spine & Nerve as soon as reasonably possible regarding controlled pain medication prescribed by another clinician.
- I understand that legitimate emergency or acute-care treatment will be evaluated in the context of my overall treatment plan and is not automatically considered a violation of this Agreement.

5. DRUG AND MEDICATION MONITORING

- If I am prescribed controlled pain medication, I may be asked to participate in urine, blood, oral-fluid, or other clinically appropriate toxicology testing.
- Testing may be used to identify prescribed medications, medications or substances not reported to my provider, or the absence of an expected medication.
- I understand that testing is intended to improve the safety of my treatment and help my provider make appropriate clinical decisions.
- An unexpected test result may require discussion, repeat or confirmatory testing, closer monitoring, modification of medication treatment, referral for additional evaluation or treatment, or discontinuation of controlled-substance prescribing when clinically appropriate.
- I understand that my provider may also request a medication count or other reasonable monitoring when needed for safe prescribing.

6. SAFE STORAGE AND DISPOSAL

- I will keep controlled medications secure and out of the reach of children, visitors, and other persons.
- I understand that secure or locked storage is recommended when appropriate.
- I will properly dispose of unused or expired controlled medications using an appropriate medication take-back or other recommended disposal method.
- I understand that sharing controlled medication can cause serious injury or death to another person.

7. RISKS OF OPIOID MEDICATIONS

If opioids are prescribed, I understand that they can cause side effects and serious complications, including:

- Sleepiness, sedation, or impaired alertness
- Dizziness, impaired balance, or falls
- Confusion or impaired judgment
- Nausea or vomiting
- Constipation
- Dry mouth
- Hormonal or other long-term effects
- Tolerance
- Physical dependence and withdrawal symptoms
- Opioid use disorder or addiction
- Respiratory depression, overdose, and death

I understand that opioids may impair my ability to drive, operate machinery, work at heights, or perform other potentially hazardous activities, particularly when starting treatment or changing doses.

8. ALCOHOL, SEDATING MEDICATIONS, AND OTHER SUBSTANCES

I understand that combining opioids with alcohol, benzodiazepines, sleep medications, muscle relaxants, other opioids, or other medications or substances that cause sedation can increase the risk of excessive sleepiness, impaired coordination, respiratory depression, overdose, and death.

I will inform my Spine & Nerve provider if I am prescribed or begin taking any medication or substance that may interact with my pain medications.

9. NALOXONE AND OVERDOSE PREVENTION

I understand that naloxone is a medication used to reverse an opioid overdose. My provider may recommend or prescribe naloxone based on my treatment and individual risk factors.

If naloxone is recommended, I am encouraged to make sure that people close to me know where it is stored and how it is used.

10. PREGNANCY

If I am pregnant, planning pregnancy, or believe I may be pregnant, I will notify my Spine & Nerve provider promptly so that the risks and benefits of my medications and treatment can be reviewed and coordinated with my obstetric provider when appropriate.

Pt initials: _____

11. CHANGES TO CONTROLLED-MEDICATION TREATMENT

I understand that Spine & Nerve may reconsider, modify, taper, or discontinue controlled-medication treatment when clinically appropriate, including when:

- The medication is not providing sufficient improvement in function, pain, or quality of life;
- The risks of continued treatment outweigh the expected benefits;
- I experience serious medication-related adverse effects;
- There is evidence of unsafe medication use, misuse, or diversion;
- Monitoring information raises significant safety concerns;
- I repeatedly do not follow medication-safety requirements or necessary monitoring; or
- A different treatment approach is clinically indicated.

Whenever clinically appropriate, changes in long-term opioid treatment will be individualized and managed with consideration of medication safety and the risk of withdrawal.

Discontinuation of controlled-medication prescribing does not necessarily mean that all medical care at Spine & Nerve will be terminated.

12. COMMUNICATION AND COORDINATION OF CARE

I authorize Spine & Nerve, as permitted by applicable law, to communicate with my pharmacy and with other clinicians involved in my care when reasonably necessary for treatment, medication safety, and coordination of care.

I understand that information may also be disclosed when required or permitted by law.

13. TERMINATION OF THE TREATMENT RELATIONSHIP

Failure to follow this Agreement may result in changes to my treatment plan or discontinuation of controlled-substance prescribing.

In some circumstances, Spine & Nerve may determine that the physician-patient relationship should be terminated. When termination of the relationship is appropriate, it will be handled consistent with applicable professional and legal requirements regarding continuity of care and notice, except when immediate action is reasonably necessary for safety.

I may also choose to discontinue treatment with Spine & Nerve at any time.

ACKNOWLEDGEMENT

I have read this Treatment Agreement. I understand its contents and have had an opportunity to ask questions. I understand that this Agreement is intended to promote safe, effective, and coordinated treatment and does not guarantee that any particular medication, procedure, test, or other treatment will be prescribed or performed.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider Name: _____

Provider Signature: _____

Date: _____

Pt initials: _____



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. I understand that if I do not pay my copay or any outstanding bill, I may be discharged as a patient. A holder of this medical debt contract is prohibited by Section 1785.27 of the California Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

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



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been given access to Spine & Nerve Diagnostic Center's current Notice of Privacy Practices. The Notice is available in the office, online at www.spinerve.com, and upon request. I understand that I may request a paper copy at any time and that the practice may revise the Notice as permitted or required by law.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or legal guardian of minor patient
- ☐ Personal representative, guardian, or conservator authorized to act for the patient

Name and Address of Patient:

AUTHORIZATION TO DISCUSS INFORMATION WITH FAMILY, FRIENDS, OR OTHERS

Please select one option below. This section allows the practice to discuss information directly relevant to my care or payment for my care with the person(s) I identify. I understand that I may change or revoke this permission at any time by notifying the practice, except to the extent the practice has already relied on it.

- ☐ I do not want the practice to routinely share or discuss my health information with anyone unless authorized below.
- ☐ I authorize the practice to discuss information relevant to my care or payment with the following person:

Name: _____ Relationship: _____

Phone (optional): _____

Patient/Representative Signature: _____ Date: _____

CANCELLATION AND NO-SHOW POLICY

To help us provide timely care to all patients, office appointments require at least one (1) business day notice of cancellation or rescheduling. Procedure appointments, including injections and nerve studies, require at least two (2) business days notice.

Office Appointments

Minimum one (1) business day notice

Procedures

(including injections and nerve studies)

Minimum two (2) business days notice

If proper notice is not provided, a no-show or late-cancellation fee may apply in accordance with the practice's current fee schedule and applicable payer requirements. The fee may be waived by management for special or unavoidable circumstances.

Repeated missed appointments or late cancellations may affect our ability to continue scheduling care. Three (3) or more no-shows within a year may result in review for discharge from the practice, subject to applicable law, continuity-of-care obligations, and the practice's discharge procedures.

If you are running late or need to cancel or reschedule, please contact the office as soon as possible. We value clear communication and will make reasonable efforts to work with you when unexpected circumstances arise.

Please sign below to confirm that you have read, understand, and agree to this policy.

Signature: _____

Date: _____

Print Name: _____

Date of Birth: _____



www.spinenerve.com

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, Dr. Brian C. Joves, Dr. Ramandeep Gurai, Dr. Jason Kung, and Dr. Julie Hastings 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, Dr. Ramandeep Gurai, and Dr. Jason Kung also have ownership interest at Fort Sutter Surgery Center, located at 2801 K Street, Suite 525, Sacramento, CA 95816.

Dr. Brian C. Joves and Dr. Julie Hastings have ownership interest at Roseville Surgery Center, located at 1420 E. Roseville Parkway, Suite 100, Roseville, CA 95661.

Dr. Ramandeep Gurai has an ownership interest at Folsom Surgery Center, located at 1651 Creekside Dr., Suite 101, Folsom, CA 95630.

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 for 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

Spine & Nerve Diagnostic Center may use electronic communication to provide appointment reminders, scheduling information, care-related messages, practice updates, and other information related to my health care.

I understand that ordinary email and text messaging may not always be encrypted or secure and may be seen by anyone with access to my email account or mobile device. By providing my contact information below, I authorize the practice to contact me by email and/or text message. I understand that this authorization is voluntary and may be changed or withdrawn by notifying the practice. Standard message and data rates may apply.

Cell Phone Number: _____

E-Mail Address: _____

MY HEALTH ONLINE (MHO)

My Health Online is Sutter Health's secure patient portal. Patients can use MHO to view test results, manage appointments, request prescription refills, and securely communicate with their care team.

Sign up for My Health Online:

myhealthonline.sutterhealth.org/MHO/signup

☐ I am already signed up for My Health Online (MHO).

☐ I would like to sign up for My Health Online (MHO).

Name (Print): _____

Signature: _____ Date: _____