ROCHESTER BRAIN AND SPINE

400 RED CREEK DR STE 120

ROCHESTER, NY 14623-4273

(585)-334-5560 (585)-334-5581 (Fax)

Orientation Agreement

Our goal is to return you to the best level of functioning to allow you to regain control of your life. You, the patient, will actively participate in your treatment regime. The following are a list of policies and commitments that as a patient you need to agree in order to effectively treat your pain and disability:

1. I understand that it is the patient's responsibility to provide a complete set of medical records including MRI, notes, labs, etc. to the clinic. This is so I may receive the best possible care.

2. I will be prepared at every visit with a full list of my medications, their dosages and how often I take them. If on narcotics, I will bring in my bottles with the unused portion of the medication at each visit.

3. Physicians at ROCHESTER BRAIN AND SPINE will not generally prescribe controlled substances/narcotics for you, however if the physician chooses to prescribe controlled substances to you, there will be an agreement signed between the parties.

a. If you have already signed an agreement with another physician, signing the agreements will not violate your existing agreement. The physicians will not prescribe controlled substance unless it is deemed appropriate to transfer this responsibility to the physician.

4. As a courtesy, the clinic may call to remind me of my appointment the day before, but ultimately it is my responsibility to keep my appointment. If unable to make my scheduled appointment, I will call and cancel (a 48 hour notice is needed). Three missed or cancelled visits may result in discharge from the practice.

5. Requests for refills must be:

a. Telephoned to the clinic at least 72 hours in advance to refill a prescription. I understand that if I give less than 72 hours notice my prescriptions may not be ready on time. Be prepared with your name, current telephone number, name and dosage of the medication and your pharmacy's telephone number.

b. Refills will not be made at night, on holidays or weekends.

c. Each prescription is expected to last at least one month. If I use up my medications sooner than prescribed, I understand that they will not be replaced.

d. Requests are to be made during regular business hours 8:00am to 4:30pm Monday through Friday. Refill prescriptions will not be given at night, on holidays or on weekends. It may be necessary for some prescriptions to be picked up in person.

e. If my pain is significantly worsened, I will go to the emergency room

f. Check bottle for refills before calling the doctor's office.

6. No prescription refills can be given if I have not been seen in the clinic within the past year. No refills for controlled substances can be given if I have not been seen for three (3) months.

7. Please feel free to call to inform us of any medication problems, however, please realize that in order to provide good care we may need to see you on follow-up in order to prescribe new medications.

8. Due to the potential use of scheduled/controlled medications, we may choose not to treat immediate relatives of current patients. Please let us know if you are related to any of our other patients.

9. There is a charge for any forms you would like us to complete. Please allow fifteen (15) business days for their completion.

10. Due to the nature of pain medicine and the prevalence if illicit drug use in our society, a baseline drug screen may be completed on my first clinic visit (and randomly thereafter). If found positive for illegal drugs or unlisted medications, continuation in the clinic may be dependant upon completion of a drug treatment programs. I am expected to be honest about any prior history of drug abuse or prescription medicine misuse. I understand that my criminal history may be screened for prior drug charges.

11. In order to prevent insurance misbilling, I will promptly update any changes in demographic or insurance information.

I have read and understand the above information. I will to the best of my ability, adhere to these policies and commitments. I further understand that non-compliance with my treatment program will delay my recovery.

_____ _____

Patient Signature Date