Form 3: Agreement for Treatment at Virginia Brain and Spine Center

Patient: _____ Date of Birth: _____

Certain medications have the potential for abuse or misuse, and we have a responsibility to minimize such occurrences. If controlled substances (such as narcotic pain medications) are prescribed for you then certain terms must be met. By signing this form, you are only agreeing to the terms if, and only if, a controlled substance is prescribed for you.

Statement of Patient Accountability Terms for Controlled Substances

Review the terms of this agreement carefully. When you sign this document, you are telling us that you (1) read it, (2) understand it, (3) agree to its terms, and (4) understand the possible consequences if you fail to follow these terms.

This agreement is only regarding the prescription of controlled substances from our practice.

1. I will only obtain controlled substances from Virginia Brain and Spine Center if given a prescription
2. I will take my medication exactly as prescribed. I agree to not change (decrease or increase) the amount of medication I take without first obtaining my doctor's permission.
3. I understand that if I obtain controlled substances from another provider while under this treatment agreement, I will no longer be able to receive controlled substances from Virginia Brain and Spine Center.
4. I understand that Virginia Brain and Spine Center does not provide long term medication management. Controlled substances will only be provided, when necessary, for a very limited time.
5. I understand that if I exhibit a history, signs, or symptoms of improper use of a controlled substance then Virginia Brain and Spine Center may choose to not provide a prescription, wean or stop prescribing, or make a referral to a Pain Management specialist for proper care.

I further understand that I must notify Virginia Brain and Spine Center if I am currently under a treatment agreement for controlled substances with another care provider and I will not be prescribed controlled substances if I am currently under a treatment agreement with another care provider.

I agree to the terms and conditions of the statements listed above

Patient Signature: _____ **Date:** _____