Carolina Center for Advanced Management of Pain

As a condition for becoming a patient in the Carolinas Center for Advanced Management of Pain (Carolina Pain Center), I agree to all the following principles:

1. I will be responsible for following the recommended treatment plan and will work with my doctor and the staff to attain my goals. This includes attending regular appointments as instructed, being on time of all scheduled appointments and activities, taking prescribed medications as ordered, and participating in all prescribed activities, including physical therapy and water therapy.
2. My attitude is the most important aspect of my treatment. I will accept responsibility for my actions and behavior and will be open to making changes in my lifestyle and habits as appropriate.
3. I will participate and cooperate, physically and mentally, in the program to the full extent of my abilities. I agree to incorporate pain-reducing techniques into my daily activities. I agree to participate in individual and/or group psychological counseling, education, physical therapy, and other modalities requested by my doctor.
4. I understand that my treatment requires significant effort on my part in order to produce the results we all desire. I also understand that the help offered to me during the program will be useless unless I accept responsibility for my treatment. I will be honest in discussing health problems and use of my medications with my physicians and nurses and will ask questions if I do not understand.
5. I understand that I will be treated by my doctor, PA, or nurse practitioner, who will work together to provide optimal care for my pain problems.
6. I agree that missed appointment, without prior notice, will be charged to me at a rate or $100 per occurrence. I understand my insurance will not cover this cost and I will be personally responsible for this cost and my appointment will not be rescheduled until this is paid. Two missed appointments will result in discharge from the practice.
7. I grant permission to the Center to send copies of my records to my referring physician and to any medical office to which I am referred from Carolina Pain Center.
8. As a prerequisite for obtaining controlled substance (pain medication and/or nerve medication) from this office, I have read and signed the pain management and opioid agreement. I fully understand this policy and agree to abide by the principles described in the agreement.
9. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of the fact, and that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercise, weight control, and avoiding the use of tobacco, alcohol, and illegal drugs. I understand that a healthier lifestyle will improve my chances at attaining pain control and improve function.

I have read this agreement, and it has been fully explained to me. I fully understand the consequences of violating this agreement.

Patient Signature: _____

Witness Signature: _____

Date: _____