

FAYETTEVILLE PAIN CENTER, PLLC.

2153 Valleygate Drive, Suite 102
Fayetteville, NC 28304

Agreement to Alternative Dispute Resolution

* _____
Patient Chart Number

In accordance with the terms of the United States Arbitration Act, I agree that any dispute arising out of or related to the provision of health care services for me by Dr. Viren Desai, the covering physician group of Fayetteville Pain Center, PLLC., or his employees and agents shall be subject to final and binding resolution exclusively through Health Care Claim Settlement Procedures of the American Arbitration Association, a copy of which is available to me upon request. I understand that this agreement includes all health care services which previously have been or will in the future be provided to me and that this agreement is not restricted to those health care services rendered in connection with any particular treatment, office visit or hospital admission.

NOTE: If the individual signing this agreement is doing so on behalf of his minor child, or any other person for whom he or she is legally responsible, then the signature below affirms that he or she has the authority or obligation to contract with Dr. Viren Desai and/ or covering physician group for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

Patient * _____ Date * _____

Witness _____ Date _____

FAYETTEVILLE PAIN CENTER
2153 VALLEYGATE DR., STE. 102
FAYETTEVILLE, NC 28304

PATIENT FINANCIAL RESPONSIBILITY

This letter is to inform you of your financial responsibility when being seen by Fayetteville Pain Center. Fayetteville Pain Center charges are for the professional services of our physicians, supplies, and/or medications used during your treatment. If you have any questions regarding your financial responsibility you may call us at (910) 323-7246.

INSURANCE/THIRD PARTY PAYORS

We will file your insurance for you as a courtesy service. All co-payments, deductibles and other amounts not covered by insurance are your responsibility. You should be prepared to pay these amounts at the time of your first appointment.

HMO's. PPO's

At the present time we do participate in many managed care companies. Please call our office to confirm those with us. Patients who belong to an HMO must go through their primary care physicians. Our physicians are specialists, and we are not able to contact these companies for needed referral numbers. This MUST be done by your primary care physician's office. This number must be called in to us before you can be seen. If we do not participate with your insurance company, payment is expected at the time of your visit.

SELF PAYMENT

If you do not have insurance or if we are unable to verify your insurance, you are considered self-pay. Payment is due, in full, at the time services are rendered.

MEDICARE AND MEDICAID

We accept assignment on Medicare and Medicaid. We do not file supplemental Medicare policies. Many supplemental insurance companies are automatically filed through an electronic filing system with Medicare. If your supplemental insurance is not one of those, you will be responsible for filing this. You will be responsible for any co-insurance amounts and deductibles specified by Medicare and Medicaid. If you have both Medicare and Medicaid, you will not be responsible for any co-insurance or deductible amounts. There are a few procedures not covered by Medicare. We will have the patients sign an Advanced Beneficiary Notice and the patient will be responsible for paying these procedures.

WORKERS' COMPENSATION

Workers' Compensation laws differ from state to state. Terms of payment will be worked out through your carrier or employer. All services must be precertified by your workers' compensation adjuster prior to services being rendered. If you are involved in a situation where your insurance company declines payment and you go into litigation, you are considered a self-pay patient and all charges will be due on the date that this information is received by our office.

DELINQUENT ACCOUNTS

All accounts over 90 days old will be turned over to a collections agency.

I have read and understand this letter. I realize that I am responsible for payment of my bill. If I need to make arrangements other than as stated above, I understand that I must contact the Billing department at Fayetteville Pain Center before my appointment time.

Signature: *_____

Date: *_____

Fayetteville Pain Center

2153 Valleygate Drive, Suite 102

Fayetteville, NC 28304

Viren Desai, MD

Authorization for Use and Disclosure of Information

Patient Name: * _____ Social Security #: * _____

Specific description of the information to be used or disclosed: _____

Persons/Organization authorized to receive the information: _____

The purpose of the use or disclosure is: _____

I understand that this authorization will expire on _____

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it will not have an effect on any actions taken in reliance on my authorization before the practice received the revocation.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that when the information is used or disclosed, it may be subject to being redisclosed and may no longer be protected by federal privacy regulations.

Patient or patient representative's signature: * _____

Date: * _____

Printed name of patient's representative (if applicable) _____

Representative's authority: _____

NOTICE TO PATIENTS: The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with the practice's policies. You may refuse to sign this authorization. We will not condition treatment or payment on your providing this authorization except in the specific circumstances allowed by the Privacy Rule.

Fees: \$10.00 Processing fee

Plus \$0.75 per page (1-25) Plus \$0.50 per page 26-100) Plus \$0.25 per page (101+)

#pages _____ x \$0.75 # pages _____ x \$0.50 #pages _____ x \$0.25

FAYETTEVILLE PAIN CENTER

2153 Vallegate Dr., Ste. 102
Fayetteville, NC 28304

Viren Desai, MD

Informed Consent for Opioid Treatment

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal government. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of the contract, and at the sole discretion of my physician, may result in the termination of our physician-patient relationship.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my plain clinic physician before making any changes.
 - I understand that increasing my dose without the close supervision of my physician could lead to drug overdose, causing severe sedation, respiratory depression and death.
 - I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, “goose flesh”, abdominal cramps and diarrhea. The symptoms can occur 24 to 48 hours after the last dose and can last up to three weeks.
2. I will not request or accept opioid medication from any other physician or individual while I am receiving such medication from my physician at Pain Management Center.
3. I understand the side effects that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation., Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician of any side effects that continue or are severe (such as sedation or confusion). I am also responsible for notify my pain physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.
4. I understand that the opioid medication is strictly for my own use. The opioid should never be given to others. If children are in the house, a child-proof top is necessary.
5. I understand I must contact my pain physician before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Soma, Xanax, or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depressing, blood pressure drop and even death. I cannot consume alcohol or use recreational drugs while on opioids. If consumed, the consequence will be termination from the program.
6. I understand that opioid prescriptions will not be mailed or called into my pharmacy. During the time that my dose is being adjusted, I will be expected to return to the clinic no less frequently than one time a month. After I have been placed on a stable dose, I will return to the clinic whenever instructed by my physician.
7. I am responsible for my opioid prescriptions. I understand that refill prescriptions:
 - Can only be written for a one-month supply and will be filled at the same pharmacy.
 - Shall be made during regular office hours, Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays or on the weekends.
 - Shall not be made if I “run out early” or “lose a prescription” or spill or misplace my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician.

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Viren Desai, MD

- Shall not be made as an “emergency”, such as Friday afternoon because I suddenly realize I will “run out tomorrow”. I will call at least one week ahead to schedule pick-up for my prescriptions.
8. While physical dependence is to be expected after long-term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification.
 - Physical dependence is common to many drugs, such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.
 - Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or “doctor shopping,” when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged.
 - Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.
 9. I understand that the goals of my pain physician’s treatment plan may include time-contingent use of opioids. If it appears to the physician that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.
 10. I agree to submit to urine and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medication.
 11. I understand that I should not drive or engage in potentially dangerous activities while taking this medication unless approved by my treating physician(s).
 12. I further understand that if I do not follow any of the above conditions or provisions, I may (at my physician’s discretion) no longer receive any type of opioid medication. I also understand that if I have a problem or question with any of the above paragraphs, I must make an appointment to discuss this with the pain physician and receive clarification before a problem or crisis situation arises.
 13. I authorize the release of any information and hospital records by the pain physician or his or her designee to other healthcare providers, my family, my employer, my insurance company or other reimbursing agencies.
 14. Physician’s office policy is not to fill any prescription of medicine by phone hence, I agree not to call physician and/or physician’s office for replacement and refill of prescription between 8am-5pm, after 5pm and on weekend. I will be required to make appointment to fill prescription in 72 hours in advance.

I, *_____ have read the above information (or it has been read to me), have received a copy of the contract and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

*_____
Patient Signature

*_____
Date

Witness Signature

Date

ACKNOWLEDGMENT

I hereby acknowledge the opportunity to review and obtain a copy of Fayetteville Pain Center's Notice of Privacy Practices.

* _____
Signature

* _____
Date