SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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PATIENTS AGREEMENT FOR CLINIC PARTICIPATION

WELCOME TO SYMPTOM MEDICINE. You have been referred to SXM by your physician for a medical evaluation. Sxm is a full spectrum pain medicine and symptom management clinic, specializing in anesthesia, pain medicine, palliative care, symptom management and hospice. A comprehensive picture of your medical history, current medical condition, and understanding of clinic policies such as patient agreements, terms of participation, financial responsibilities, and controlled substance policies, are important before commencing your care.

1. I understand, I must always be under the care of primary care physician (PCP) who is responsible for the direction of my care. I understand protected health information will be exchanged between governmental agencies, pharmacies and/or health care providers regarding my medical care, medical records, prescriptions, treatment and medication use.
2. I will disclose all of my treating physicians, treatment clinics, and health care providers. I will disclose a list of all of the medications that I am taking, I will disclose all of the pharmacies that I am receiving medications from
3. Furthermore, I understand I need to inform the clinic of any new medications prescribed by another health care provider
4. If I have a medical condition that is not chronic in nature, and needs immediate medical attention, I will call 911 or go to your nearest emergency room. I must notify the Clinic for any visits to the emergency room or urgent care centers.
5. I understand emergency room or urgent care clinic visits for opioids or controlled substances is direct violation of clinic policy. Chronic pain and chronic symptoms are not considered an emergency; therefore, all non-urgent calls and appointments must be completed during clinic business hours.
6. At any time during my care at Symptom Medicine, I may be required to be evaluated by an independent psychologist or psychiatrist specializing in pain management to continue care at the clinic and to be prescribed any controlled substances, including opioids. Of note, consultation services from Behavioral medicine, psychologist or psychiatrist, are not provided, covered or paid for by Symptom Medicine
7. If my PCP request medication management, I understand I will be required to read the Controlled Substance and Opioid Educational module, sign an opioids contract agreement and adhere to all clinic rules.
8. I understand, every SxM clinic patient is subject to periodic random laboratory tests, including blood and/or urine toxicology screening (drug screening. Any inconsistent reports may result in discharge from the clinic.
9. I understand, I am responsible for keeping abreast of what I owe on my account and any outstanding balances due. Credit cards and automatic check withdrawal on file will be charged for any outstanding balances or fees due within 24 hours preceding my appointment or at the end of each billing cycle, whichever is first.
10. I understand that if I give less than a 24 hour notice for appointment cancellation, I will be charged $50.00. This fee cannot be applied to my insurance or deductable or be billed to my health plan policy.
11. I understand I may be discharged from the clinic for missed appointments and all subsequent care will be continued sby my PCP. For example, absent from the clinic greater than ten months; more than 3 unplanned missed appointments per year; three or more cancelled appointments during a 12 month period
12. Binding Agreement to Arbitrate: The undersigned understands and agrees to arbitrate any dispute and/or claim arising from any, direct or indirect, Clinic service, including but not limited to any service, treatment, medical malpractice, personal injury, privacy. The Undersigned agrees that any complaint or claim must be arbitrated (binding) and not by lawsuit or resort to court process as California law provides for judicial review of arbitration proceedings.
13. Disruptive, violent, threatening and/or abusive language or action by any patient or patient representative will not be tolerated and will result in a discharge from the clinic. If necessary a police report will be filed.

 Name_____ Initals _____

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I, the undersigned, have read, understand and agree to fully comply with all the Terms and Condition of Agreement of Clinic Participation, Terms and condition of service, Patient Agreement of Financial Responsibility. All of my questions have been answered. Failure to comply with any such terms, rules and/or polices may result in the discharge from Clinic. The continuation and subsequent care will be under the discretion the PCP and referring physician.

Responsible Party (If other than Patient, indicate relationship): The undersigned patient certifies that he/she has read the foregoing, received a copy thereof, and is Patient, legal patient representative or duly authorized by the Patient (as the Patient's Representative) to execute the above and to accept its terms on behalf of Patient who shall be bound thereby.		
Patient Signature	**Name: (First Last))**	**Date and Time**
Patient Representative Signature	**Name: (First Last) and Relationship**	**Date and Time**
Witness Signature	**Name: (First Last)**	**Date and Time**

Financial responsibility agreement by person other than Patient: I agree to accept joint and several financial responsibility with Patient for services rendered to Patient and accept the terms set forth above and received a copy.		
Patient Signature	**Name: (First Last)**	**Date and Time**
Patient Representative Signature	**Name: (First Last) and Relationship**	**Date and Time**
Witness Signature	**Name: (First Last)**	**Date and Time**

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