COLUMBIA CLINIC
Pain & Ortho-Spine Institute

Usama A. Gabr, MD, FAAPMR, CIME
Physiatry & Rehabilitation Associates

12. I consent to random drug screening to assure I am taking medications as prescribed. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I am taking.
13. **I will keep all my scheduled appointments.** If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.
14. I understand that this physician **may STOP** prescriptions if:
    a. I do not show any improvement in pain or my activities have not improved.
    b. I develop rapid tolerance or loss of improvement from treatment.
    c. I develop significant side effects from medications.
    d. I break any part of this agreement outlined above, which may also result in being prevented from receiving further care from this clinic.
    e. I refuse to consent to drug screenings.
    f. I fail to comply with other treatment recommended by this Pain Clinic providers including, but not limited to, physical therapy, occupational therapy, and physiatric treatment.
    g. **I will not miss more than two consecutive APPOINTMENTS for procedures in a 6 month period;** knowing that I may be referred to another provider for this reason.
    h. If my physician for any reason that the pain treatment is not advisable.
15. If the decision is made to discontinue medications or management secondary to non-compliance, irregular behavior or disruption of clinic policy and/or regulations, possible withdraw! Symptoms may occur and will need immediate medical help at a hospital or emergency room for detoxification program which is likely an in-patient setting since these symptoms can be life-threatening. I am aware of this fact.

I have read this form or have had it read to me. I understand all of it. I have had the chance to have questions regarding this form answered to my satisfaction. I am signing this form voluntarily and have full right and power to be bound by this agreement.

_____ _____

Patient signature Date

_____ _____

Staff signature Date