

TREATMENT AGREEMENT

I, _____, hereby agree to adhere to the following treatment agreement while under the care of Jeffrey B. Glaser, M.D. for my pain condition(s).

- Dr. Glaser is an interventional pain doctor whose primary purpose is to treat functional disorders causing pain with minimally invasive treatments. I understand that Dr. Glaser will not be prescribing long term medication management for my pain and that I must consult with my primary care doctor for such prescriptions.
- All medications I am taking must be disclosed to Dr. Glaser at each of my visits.
- I will advise Dr. Glaser when another physician prescribes PAIN medication for me.
- I must bring all my medications to each visit for Dr. Glaser to see.
- I will only use one pharmacy for ALL my prescriptions and will advise Dr. Glaser immediately if this pharmacy changes. My pharmacy name and phone number are as follows:

PHARMACY NAME

PHONE NUMBER

- Dr. Glaser will not prescribe medications over the phone. An office visit will be required to obtain a prescription. **No exceptions.**
- Dr. Glaser will not give medical advice over the phone. I must make an appointment to be seen if I need advice. **No exceptions.**
- If I feel I am having a medical emergency I will go the nearest emergency room.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

DATE

PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE

RELATIONSHIP TO THE PATIENT

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