PATIENT – PHYSICIAN MEDICAL CARE AND DIAGNOSTIC TESTING AGREEMENT

VERY IMPORTANT – READ CAREFULLY BEFORE YOU SIGN!

PATIENT/ADDRESS: _____

CAREGIVER(S)/ ADDRESS(ES): _____

1.) ____The patient/caregiver(s) agree(s) (herein referred to as "patient") that in order to continue medical care with this center, including the provision of medications and Controlled Substances, and to more precisely determine the cause of their symptoms and any appropriate, definitive treatment that may be indicated, the following must be adhered to:

a.) ____ The Diagnostic Testing outlined at each visit, must be completed within 6 weeks of having been ordered. This includes:

- X-rays
- MRI scans
- CT scans
- Myelograms
- Bone Scans
- Discograms
- Root Blocks
- EMG
- Nerve Conduction Testing
- Evoke Potentials Testing

b.) ____ Patient must notify this office if an unforeseen event has occurred and will interfere with the timely completion of the testing.

2.) ____ Should the patient not adhere to or otherwise violate this AGREEMENT, furnish false information or **NOT COMPLETE THE DIAGNOSTIC TESTING**, then the patient may be discharged from the physician's care, with two weeks notice being given immediately, in writing, sent to the patient's last address of record. Alternative consequences will be at the discretion of the physician.

3.) ____ By my signature below, I ATTEST that I have read and will abide by the above Agreement. I understand the failure to do so, may result in discharge from the physician's care, as outlined in #2.

SIGNATURES:

Patient: _____ Caregiver(s): _____

Date: _____ Physician: John A. Campa III, MD

Witness: _____