



Metropolitan Pain Management Consultants, Inc.  
Lee T. Snook, Jr., M.D.

Treatment Contract

Metropolitan Pain Management Consultants, Inc. and \_\_\_\_\_  
agree to the following treatment plan:

1. Treatment Goals: \_\_\_\_\_

2. Services to be provided by MPMC:

- \_\_\_\_\_ One time evaluation and consultation with recommendations for referring physician
- \_\_\_\_\_ Consultation for medication management with stabilization and return to Primary Care Physician
- \_\_\_\_\_ Consultation for procedures only
- \_\_\_\_\_ Consultation for procedures and medication management
- \_\_\_\_\_ Other: \_\_\_\_\_

3. Services to be provided by other agencies:

- \_\_\_\_\_ Diagnostics: \_\_\_\_\_
- \_\_\_\_\_ Psychologist: \_\_\_\_\_
- \_\_\_\_\_ Psychiatrist: \_\_\_\_\_
- \_\_\_\_\_ Other: \_\_\_\_\_

4. MPMC plans to develop a plan of care which should allow an attainment of the above goals within approximately \_\_\_\_\_ visits or \_\_\_\_\_ months.

5. I understand that my MPMC provider recommends the above listed services. I understand that it is my choice to receive these services however, if I chose not to comply with these recommendations, my MPMC provider will return my care to my referring physician or my Primary Care Physician.

6. I understand that to maintain an active status with MPMC, I must keep my scheduled appointments with both MPMC and the specialist providers with whom I have been referred.

7. I understand that if I am prescribed medications, I must comply with the Medication Agreement.

8. I understand that I must pay my co-payment at each visit and that I must keep my account current.

9. I understand that if I fail to maintain my obligations described above that I may be discharged from MPMC.

This agreement may be amended by the agreement of both parties.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

CC: Referring Provider