Patient Responsibility Agreement for Controlled Substances Prescriptions

Controlled substance medications (*ie* narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled and monitored by the local, and state, as well as the federal government. The conditions outlined here are designed to keep both patient and physician within the bounds of applicable laws. By accepting a prescription for a controlled substance, I understand and agree to the following:

1) I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, stolen, or if I "run out early", I understand that it will not be replaced.
2) Concerning refills of controlled substances, I understand that:
    a. We will make every effort to refill these medications if they are being used in an appropriate manner before we leave for the day. We cannot guarantee that all appropriate refills will be called in the same day. **Please allow 48 hours.**
    b. Refills will not be made on an "emergency" basis such as **Friday after 12:00 PM** or **over the weekend.**
3) I will not obtain controlled substances from any other physician or any other person with a prescription for the same or similar medication.
4) I understand that the use of controlled substances may impair my ability to operate motor vehicles or heavy equipment. It is my responsibility to comply with the laws of the state while using controlled substances.
5) I understand that if used according to prescription, the true addictive potential of these medications is small, but tolerance or other dependency may develop. These may be managed by adjustments in dosage or tapering of the medications. In some cases, referral to a pain management physician may be necessary.
6) I understand that controlled substances do not "mix well" with alcohol.
7) I agree to have all of my prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the prior pharmacy will be so notified by this office. The pharmacy that I have selected is:

Pharmacy name_____ Location or Phone # _____

8) I understand that if I violate any of the above conditions, my prescriptions for controlled substances will be terminated immediately. I further understand that such violation may be reported to all of my physicians, to medical facilities, to pharmacies, and if required by law, to appropriate authorities.

I have read this contract and have had the opportunity to have all questions answered. I understand and agree to the terms.

Printed Name _____ Date _____

Patient Signature_____ Date _____