



## **PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS**

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician may prescribe controlled substance medications to help manage my pain, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced or stolen or if I “run out early,” I understand that it will not be replaced.
2. Refills of controlled substance medications:
  - a. Will be made only during regular office hours Monday through Friday. Refills will not be made at night, on weekends, or during holidays.
  - b. Will not be made if I “run out early” or “lose a prescription,” or “spill or misplace my medication.” I am responsible for taking the medication in the dosage prescribed and for keeping track of the amount remaining.
  - c. Will not be made as an “emergency,” such as on Friday afternoon because I suddenly realize I will “run out tomorrow”. I will call at least twenty-four (24) hours ahead if I need assistance with a refill.
3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.
4. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.
5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.
6. I understand that the main treatment goal is to reduce pain and improve any ability to function and/or work. In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
7. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances.
8. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

9. If you are currently receiving prescription pain medications from another physician or surgeon of any specialty, please list the names and dosages of all such medications and the names of the prescribing physicians. If you are not currently receiving prescription pain medications, please write "NOT RECEIVING".

10. I agree to adhere to the treatment regimen as deemed appropriate by Dr. Oishi in regards to prescription medications as long as I am under his care. I will not seek prescription pain medications from other physicians except when mutually agreed between Dr. Oishi and myself. I agree that when Dr. Oishi has deemed that my treatment is complete and/or he has released me from his care, I will no longer seek prescription pain medications from his office, as I recognize that he is a surgeon and not a pain management specialist.

I have read this contract and I fully understand the consequences of violating this agreement.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Patient Name Printed \_\_\_\_\_