PAIN AND SPINE CARE
MASROOR AHMED, M.D.

PATIENT RESPONISBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (I.E. Narcotics, Tranquilizers and barbiturates) are useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal government. They are intended to relieve pain, thus improving function and/or ability to work. Because my Physician is prescribing 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, STOLEN OR I "RUN OUT EARLY,"** I understand that it **WILL NOT** be replaced. **IF STOLEN, A POLICE REPORT WILL NEED TO BE FILED WITH YOUR LOCAL POLICE.**
2. Refills of Controlled Substance Medications **WILL BE MADE ONLY DURING REGULAR OFFICE HOURS,** during a scheduled visit. Refills **WILL NOT** be made at night, over the weekend, or during Holidays. **NO REFILLS WILL BE MADE OVER THE PHONE FOR ANY TYPE OF PAIN MEDICATION.** I am responsible for taking the medication in the dose prescribed and for keeping track of how many are remaining. I will call in at least 24 hours ahead if I realize I'm about to run out over the weekend or Holiday. If the Doctor agrees to write a prescription **I MUST** come pick it up **IN PERSON** at the office.
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 an 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 agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. 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. Quality and effective pain treatment relies heavily on off label use of numerous drugs. Any physician may prescribe any marketed drug for an indication or in a dosage that he/she deems appropriate even though it may not be listed in publish indication.
6. I understand that the main treatment goal is to reduce pain and improve any ability to function and/or work. I agree to help myself by following better health habits, exercise, weight control and avoidance of the use of tobacco and alcohol. I understand that the long-term advantages and disadvantages of Chronic Opiod use have yet to be scientifically determined and my treatment may be changed at any time and my Physician will advise me of any advances in the field, or make treatment changes as needed.
7. I understand that **IF I VIOLATE ANY OF THE ABOVE CONDITIONS,** my prescription for Controlled Substance Medication may be terminated immediately. If the violation involves obtaining Controlled Substance Medication may be terminated immediately. If the violation involves obtaining Controlled Substance Medication from another individual, or the use of illicit (illegal) drugs, I may also be reported to ALL my Physicians, Medical Facilities and appropriate authorities.

_____ _____
Patient Signature Date

_____ _____
Office Employee Date