

# MPMC

## AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced. I am aware that I must report stolen medications to the police.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my doctor at Metropolitan Pain Management Consultants. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.
3. Refills of controlled substance medication:
  - a) Will be made only during regular office hours 9:00 AM to 5:00 PM Monday through Friday, in person, once each month during a scheduled office visit. Refills will not be made at night, on holidays, or on weekends.
  - b) Will not be made if I "run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left.
  - c) Will not be made as an "emergency", such as Friday afternoon because I suddenly realize I will "run out tomorrow." I must keep track of my medication and plan ahead. I will call at least twenty four (24) hours ahead if I need assistance with a controlled substance prescription.
4. I am aware that under California Vehicle Code section 23152 it is unlawful to operate a motor vehicle under the influence of drugs and alcohol and this includes prescribed medications. It is my responsibility to know the side effects of the medications I am taking and which medications may affect my ability to drive. It is also my responsibility to arrange transportation to my office visits if I am unable to drive safely.
5. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal, and that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits, specifically involving exercise, weight control, and the use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
6. I understand that my treatment program may include some or all of the following: regular office visits, psychiatric evaluation, lab tests, physical therapy, support group or group therapy, and a drug and /or alcohol rehabilitation treatment program. I agree to participate in the treatment program designed for my best recovery.
7. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment at Metropolitan Pain Management Consultants may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my primary physician, local medical facilities, and other authorities.
8. I have been fully informed my doctor and his staff about psychological dependence (addiction) of a controlled substance, which I understand, is rare. I know that some persons may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

Patient: \_\_\_\_\_ Witness: \_\_\_\_\_ Date: \_\_\_\_\_