Patient responsibility agreement for controlled substance prescriptions

Eric I. Ray, M.D.
731 E Southlake Blvd, Ste 110
PHONE 817-898-7277 FAX 817-527-5119

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 is prescribing controlled substance medications to help mange 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 medications:
    a. Will be made only during regular office hours, Monday through Friday, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends or during holidays. No refills by phone.
    b. Will not be made if I "run out early", "lose a prescription", or "spill or misplace my medication." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    c. Will not be made as an "emergency", such as on a Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 24 hours ahead if I need assistance with a refill, which must be refilled in person in the office.
3. I understand that any medication prescribed may not be as effective to control my pain; therefore I will need to return any unused medication to the doctor to be discarded in order to get a new prescribed medication.
4. 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.
5. I agree to comply with a random urine, blood, or breath testing to document the proper use of medication, 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.
6. 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.
7. I understand that the main treatment goal is to reduce pain and improve any ability to functions 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 tobacco and alcohol use. 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.
8. 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, and that my physician will advise me of any advances in this field and will make treatment changes as needed.

I have been fully informed by SOUTHLAKE PAIN CENTER/ Dr. Ray or his staff regarding the psychological dependence (addiction) of controlled substance medication, which I understand is rare. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect. I know that there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I know I must slowly decrease the dose while under medical supervision or I may have withdrawal symptoms.
I have read this contract and the same has been explained to me by SOUTHLAKE PAIN CENTER/ Dr. Ray. On addition, I fully understand the consequences of violating this agreement.

_____ _____
Patient Signature Date

_____ _____
Print Name Witness