Lake Physical Medicine

PATIENT PRESCRIPTION RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCES

1. I am responsible for the controlled substance medications prescribed to me. If any prescription is lost, misplaced or stolen or if I "run out early", I understand that it will not be replaced.

2. REFILLS ON CONTROLLED SUBSTANCE MEDICATIONS:
    a. Will be made only during regular office hours, in person once a month, during a scheduled office visit, or on the phone two days in advance. Refills will not be made at night, on weekends, or during holidays.
    b. Prescription will not be filled if I "run out early", lose a prescription, spill or misplace my medications. I am responsible for taking the medication in the dose 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 realized I will run out tomorrow. I will call 2-3 days prior to a refill.

3. I will not be rude to the office staff on the phone or in the office.

4. I agree to comply with random urine, blood or breathe testing, documenting the proper use of 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 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 involved obtaining controlled substance medications from another individual or the use of non (illegal) prescribed drugs, I may be reported to all my physicians and the appropriate law enforcement authorities.

6. I understand that the main treatment goal is to reduce pain, improve my ability to function and work. In consideration of this goal, I agree to help myself by following better health habits, exercise, weight control and avoidance of the use of tobacco and alcohol.

7. I agree to only receive controlled substance medications while receiving pain management intervention from Dr. Patrick Boylan and not by any other medical professional. I understand that violation of these conditions will result in immediate removal from Oaktree Clinic as a patient and that I will have no recourse against Dr. Boylan. I am solely responsible for the procurement of any tapering doses required to avoid withdrawal when discharged from the practice.

8. I agree to provide Dr. Boylan with my pharmacy's contact information at which I will fill all my prescriptions from Dr. Boylan. If I require changing pharmacies, I agree to notify Dr. Boylan.

PATIENTS SIGNATURE:_____ DATE:_____