HOUSTON NEUROLOGICAL INSTITUTE

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Patient Responsibility Agreement for Controlled Drug Prescriptions

Controlled substance medications (i.e. narcotics, tranquillizers 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 manage my pain, I agree to the following conditions:

1. I am responsible for the controlled medications prescribed for 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

   - Will be made during regular office hours, Monday thru Friday, in person, once a month. Refills will not be made at night, on weekends or during holidays.

   - Will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication." I am responsible for taking my medication in the dose prescribed and for keeping track of the amount remaining.

   - 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 2 business days ahead if I need assistance with a refill, which must be done 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 may no longer be refilled.

4. I understand that driving a motor vehicle may not be allowed while taking controlled 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 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. By signing below, I specifically authorize the release of information for this purpose.

6. 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 substance medication and that my physician will advise me of any advances in this field and will make treatment changes as needed.

7. I will not obtain or attempt to obtain controlled substance medications from another physician while obtaining from this office.

I have been fully informed of the risks of psychological dependence (addiction) of controlled substance medication, which I understand is rare. I know that some individuals may develop a tolerance to the medication, 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 have had the opportunity to ask questions. In addition, I fully understand the consequences of violating this agreement.

PATIENT COPY PLEASE KEEP

This copy is for informational purposes only so you as a patient will be aware of our policy regarding controlled substances.

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