NEUROSURGERY AND SPINE SPECIALISTS

Patient Controlled Substance Agreement Informed Consent Form

The following agreement relates to my use of controlled substance for chronic pain prescribed by Neurosurgery and Spine Specialists. I recognize that these are policies regarding the use of controlled substances that are followed by the staff. I will be provided controlled substances while actively participating in my treatment plan ONLY if I adhere to the following regulations:

1. I will use the substances only within the parameters given by my treating physician.

2. I will not receive replacement medications for "lost" or "stolen" medications without presenting a valid police report.

3. I will receive controlled substances only from Neurosurgery and Spine Specialists relating to my surgery or treatment plan. Any controlled substances prescribed outside Neurosurgery and Spine Specialists will lead to discontinuation of treatment.

4. I will not expect to receive additional medication prior to the time of my next scheduled refill regardless if my new prescription runs out. I will be responsible for "stretching out" my medications if my new prescription is dated for a weekend, holiday or any other date when I cannot refill my prescription. I understand that prescriptions will not be rewritten for a new day under any circumstances.

5. Under no circumstances will a refill of a Schedule II narcotic (controlled substance) prescription be given over the telephone.

6. By law, a maximum of thirty (30) days supply of medicine will be prescribed at any one time.

7. I will accept generic brands of my prescription medications.

8. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medications as prescribed by the physician. I will not hold any member of Neurosurgery and Spine Specialists liable for problems caused by discontinuation of controlled substances, provided that I receive 15 days notice of termination.

9. I agree to submit to urine and blood screens to detect the use of non-prescribed medications at any time.

10. I agree to medication counts as needed, within a 24-hour notice.

11. I recognize that my chronic pain represents a complex problem which may benefit from behavioral medicine strategies and psychotherapy. I also recognize my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of my treatment plan as directed by my physician in order to secure increased function and improvement in learning how to cope with my condition.

12. I am permitting the right of disclosure to law enforcement in the event of violation or breach of this agreement.

Patient Signature	Date	Physician Signature	Date

Witness, Family Member or Significant Other Signature	Date

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