

GULF COAST ORAL and FACIAL SURGERY, PA

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It is the policy of Gulf Coast Oral and Facial Surgery to deliver quality care and treatment to all our patients.

**Patient Responsibility Agreement for Controlled Substance Prescriptions**

Controlled substance medications (i.e. narcotics 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. Because my Doctor is prescribing controlled substance medications to help manage my 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, stolen or if I 'run out early', I understand that it will not be replaced without an office visit.
2. Refills of prescription medications:
  - A. Will be made only during regular office hours Monday through Friday (office closes at noon on Fridays). Refills will not be made at night, on weekends, or during holidays.
  - B. Will not be made over the telephone, if I 'run out early' or 'lose a prescription', or 'spill or misplace my medication'. An office visit will be required. 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 realize I will 'run out tomorrow'. I will call at least 24 hours ahead if I need assistance with a refill.
  - D. Pain medication *will not* be provided to those under the care of pain specialist.
3. 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.

I have read this contract and I fully understand that the consequences of violating this agreement may result in the termination from this practice.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_