



North Texas Family Medicine
 1340 North Hwy 377 Suite 110
 Pilot Point, Texas 76258

940 686 0860

Patient Responsibility Agreement
 for Controlled Substance Prescriptions

Lisa L. Houk, APRN, BC

Robert Helsten, MD

Controlled substance medications, (ie. 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, stress, and sleeplessness, thus improving function and/or ability to work. Because my provider is prescribing controlled substance medications to help manage my care, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, missing, or stolen, or if I "run out early", I understand that it will not be redispensed. I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
2. Refills of controlled substance medications:
 - a. will be made only during regular office hours, Monday thru Friday, in person, once a month, during a scheduled office visit.
 - b. will not be made at night or on the weekends or by phone.
 - c. will not be made if I "run out early" or they are missing for any reason.
 - d. will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
 - e. 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. It may be deemed necessary by my provider 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 medication will no longer be refilled.
4. I agree to comply with random urine, blood or breathing testing, documenting the proper use of my 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 the state.
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 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 providers, medical facilities, and appropriate authorities.
6. I understand that the main treatment goal is to improve ability to function 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.
7. 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 provider will advise me of any advances in this field and will make treatment changes as needed.

I have been fully informed of the NTFM policy regarding psychological dependence, (addiction) of controlled substance medication by reading the above. I know that it may be necessary to stop taking the medication at any time deemed necessary by the provider. If so, I know I must slowly decrease the dose while under medical supervision or I may have withdrawal symptoms.

By signing this contract, I agree to only use NTFM for all controlled substances. If any other provider prescribes them, then NTFM will no longer provide any controlled substances.

I agree to use only one pharmacy location for receiving my controlled substances, which is:
 _____ Pharmacy at _____, Texas at phone number _____.

I have read this contract in its entirety. If at any time, I violate this agreement, I understand the consequences, which may include immediate dismissal from the NTFM practice for one year or indefinitely.

Patient Signature _____

Witness _____

Date _____