SOUTH COAST NEUROLOGY, INC.

Agreement for Controlled Substance Prescriptions

Your provider has decided to prescribe a controlled medication for the treatment of your pain/attention/mood and/or fatigue. The prescriptions of opioids ("narcotics") and of Amphetamines are regulated strictly by the Federal Drug Enforcement Agency (DEA) and by state authorities. Your provider will write for the type, quantity, and dose of medication that in his/her best judgment is appropriate for the treatment of your pain/attention/mood and/or fatigue. By signing this agreement you voluntarily are pledging to adhere to the following regulations:

1. I understand that the prescriptions and medications I receive under the terms of this agreement are my responsibility once they are placed in my hand. If anything happens to the prescription or medication (eg, it is lost, stolen, damaged, etc.), I will not request a replacement prescription; to assist with symptoms that I may experience consequent to withdrawal from the medication in question, a prescription for clonidine may be called into my pharmacy. If my prescription or medication was stolen, I will be required to provide a police report on or before my next scheduled appointment. I understand that the medication being prescribed for me must be kept in a secure location.

2. I will follow the prescription schedule written by my provider, including the date of my next refill and the number of refills. I understand that if I use more medication than the amount prescribed for the time indicated, no additional medication will be prescribed until the refill date. If I repeatedly request early refills of my pain medication, I understand that my provider may decide to stop prescribing that medication altogether.

3. I will only obtain prescriptions for the controlled medications indicated above from my provider. If I receive controlled medication from another source for a new or worsening condition, I will notify him of this as soon as possible.

4. I have informed my provider of any past or present use of alcohol or other recreational drugs. I understand that I should not drink alcohol or use other recreational drugs while taking controlled medications.

5. I understand that prescriptions for the controlled medication(s) indicated above will not be called in or written after office hours by my provider or a physician covering for him/her.

6. I understand that controlled medications may impair the mental or physical ability required to perform potentially hazardous tasks such as driving a car or operating any dangerous or motorized vehicles or machinery. I understand that I should not perform such tasks if the controlled medication I am taking clearly is impairing those abilities.

7. I understand that the controlled medication(s) may be discontinued by my provider if I fail to achieve the treatment goals he has set. I understand that treatment will be discontinued if I obtain controlled medication from other sources, fill my prescriptions for controlled medication at multiple pharmacies, sell, give away, or otherwise divert the controlled medication from its intended use, alter my prescription in any way, change my dosing regimen without first consulting with Your provider and receiving his assent or miss three consecutive appointments (cancellation or no show).

8. I understand that risks associated with long-term use of controlled medications may include physical dependence, tolerance, constipation, sleep changes, potential for an eventual increase in pain, injury to unborn children, appetite change, impaired coordination, and impaired sexual desire or performance. I understand that stopping controlled medication abruptly can cause withdrawal symptoms.

10. I understand that if I violate any portion of this agreement, my treating physician may decide to terminate our professional relationship. I understand that my provider is under no obligation to provide me with medication for acute or chronic pain if he feels such treatment has not proven to be sufficiently effective. I have been provided with a copy of this agreement and understand that I may discuss any questions or concerns I have regarding its content with my treating physician.

Print Name (Patient) Signature of Patient (SEAL)

Witness Date

This form is valid for one calendar year.

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