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**GOLDEN TRIANGLE NEUROCARE, LLP.**

It is the policy of Golden Triangle Neurocare to deliver quality care and treatment to all our patients. Taking into account the nature of our specialty, we realize that many of our patients come to us with chronic or some level of pain. It is our hope and belief that this pain can be treated conservatively through non-narcotic medication or surgical intervention if required.

**Patient responsibility agreement for controlled substance prescriptions**

Controlled substance medications (i.e. 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, 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 substance medications prescribed to 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:
  - a. Will be made only during regular office hours Monday through Friday. Refills will not be made at night, on weekends, or during holidays.
  - b. Will not be made if I "run out early" or "lose a prescription", or "spill or misplace my medication." 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 hrs ahead if I need assistance with a refill.
  - d. Triplicate prescription narcotic pain medications will not be administered.
  - e. Pain medication will not be provided to those under the care of a pain specialist.
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 medication will no longer be refilled.
4. 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 nonprescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.
5. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given 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. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
6. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_