SWENSON FOOT & ANKLE

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers and barbiturates) are very useful, but have high potential for misuse and abuse. Therefore, they are clearly controlled by the local, state and federal government. They are intended to relieve pain, to improve function, and/or ability to work, not simply to feel good. Due to the fact my doctor is now or may be prescribing such medication for me in the future to help manage pain, I agree to the following conditions:

1. **I am responsible for my controlled substance medication.** If the prescription is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand **it will not be replaced.**
2. **I will not request nor accept** controlled substance medication from any other physician or individual while I am receiving such medication from my doctor at Swenson Foot & Ankle without informing my doctor immediately. Besides being illegal to do so under NRS 453.391, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.
3. **Refills** of controlled substance medications:
    a. **Will be made only during the hours of 8:00 a.m. to 4:30 p.m.** Refills **will not be made** at night, on holidays or on weekends.
    b. **Will not be made** if I "run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left
    c. **Will not be made** as an "emergency," such as on Saturday afternoon because I suddenly realize I will run out "today." I must keep track of my medication and plan ahead. I will call **at least 48 hours ahead if I need assistance** with a controlled substance medication prescription.
4. I understand **if I violate any of the above conditions,** my controlled substance prescription and/or treatment at Swenson Foot and Ankle may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to local medical facilities and other authorities.

I understand the **main treatment goal is to improve my ability to function and/or work.** In consideration of the goal and that I have been or may be given potent medication to help me reach that goal, **I agree to help myself by following better health habits,** specifically involving exercise, weight control and the use of tobacco or alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

____ ______________________
Patient Name (Print) Date

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Signature of Patient (Parent or Guardian if minor)

MEDICATION HISTORY AUTHORITY

Our office is implementing an Electronic Health Record system through athenahealth that will automatically import the last 13 months of your medication history. This information is downloaded from the pharmacy benefits manager utilized by your health insurance plan.
By signing below, I hereby authorize SWENSON FOOT & ANKLE to download my medication history.

____ ______________________
Signature of Patient (Parent or Guardian if minor) Date

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Print Name