NEUROSPINE INSTITUTE
ROBERT L. MASSON, M.D.

PATIENT CONTRACT BETWEEN NEUROSPINE INSTITUTE AND PATIENTS WHO ARE PRESCRIBED CONTROLLED SUBSTANCES FOR CHRONIC PAIN

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

Patients being treated with long-term use of such substances, such as opiods (NARCOTIC pain medicines) tranquilizers, muscle relaxants and barbiturate sedatives have some risk of developing an addictive disorder or developing or suffering a relapse of a prior addiction. The extent of this risk is not certain.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason we require each patient receiving treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your pain caused by your spinal condition.

1. All controlled substances must come from a practitioner in this office. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering practitioner unless specific authorization is obtained for an exception.
2. I will inform my physician of any current or past substance abuse.
3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform the Neurospine Institute staff. The pharmacy I am selecting is:
   ________________________ (pharmacy) __________________ (phone)
4. I will inform the Neurospine Institute office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
5. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.
6. I will not allow anyone else to have, use sell, or otherwise have access to these medications.
7. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
8. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.
9. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.

10. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder.
11. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
12. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged or stolen prescriptions twice within a year I will possibly be discharged from the practice.
13. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.
15. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. I will keep my scheduled appointments in order to receive medication renewals. No refills will be given at night or on weekends.
17. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on whether my physician believes that the medication usage benefits me.
18. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal and over dosage.
19. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accepts all of its terms.
20. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

_______________________________	_______________________________
Physician Signature	Patient Signature
_______________________________	_______________________________
Date	Ptient Name (printed)