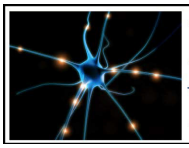
CSMMIRA



FIVE TOWNS NEUROLOGY

923 Broadway, Woodmere, NY 11598 516 239 1800 - Fax: 516 295 5557

CONTROLLED SUBSTANCE/MEDICAL MARIJUANA - INITIAL/REFILL AGREEMENT

TO BE COMPLETED FOR EVERY TIME A PATIENT GETS A REFILL OF CONTROLLED SUBSTANCE

Patient Name _____ DOB: ___/___/___ Today's date: ___/___/___

(If other than patient completing form: Your Name: _____ Relation: _____

Pharmacy Name: _____ City: _____ State: ___ Phone: _____

Current Controlled Substances:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Reason for my use of controlled substance(s): (Check all that apply)

❑ Pain ❑ Anxiety ❑ ADD/ADHD ❑ Seizures ❑ Appetite

IN ORDER TO RECEIVE REFILL/ONGOING CONTROLLED SUBSTANCE YOU MUST AGREE TO ALL OF THE FOLLOWING (INDICATE BY CHECKING EACH BOX)

❑ 1. I will take only amount/frequency of controlled substance prescribed to me
❑ 2. Any changes (made by other doctors) temporarily or long term require NOTIFICATION to our office and ongoing use requiring APPROVAL of our office
❑ 3. I testify that I have a legitimite reason for my initial/ongoing use of controlled substance prescribed (antici pated benefit for a real condition and/or actual benefit if I am already taking)
❑ 4. I understand that the office requires 72 business hours advance notice prior to refilling any needed con trolled substance refill
❑ 5. This office does not and will not fill any emergency refills, nor regular refills on nights and week ends (and I will plan accordingly)
❑ 6. I cannot and will not receive medication from any other source, no doctor, hospital, emergency room (with out notifying this office) nor in any circumstance from friend, family member or stranger
❑ 7. I will never SHARE, SELL or LEND my controlled substances with anyone for any reason
❑ 8. I will discard all discontinued controlled substances within my home (in a safe fashion)
❑ 9. I will use only the pharmacy specified above and notify this office of any changes
❑ 10. I give full permission to discuss my use of my controlled substance medication to relevant pharmacies, healthcare providers and insurance providers as related to my condition and care
❑ 11. I understand that this office requires controlled substance urine/sputum testing, attestation of ongoing safe use and refill agreements and my noncompliance will result in my removal from the program (I won't get refills)
❑ 12. Lost, Misplaced and/or Stolen medication WILL NOT BE REPLACED
❑ 13. ***ANY BELLIGERENT OR AGGRESSIVE BEHAVIOR*** (AS DEEMED BY OUR PROFESSIONAL AND CLERICAL STAFF) OF ANY KIND (Including but not limited to: Shouting, Screaming, Demanding, Threatening, Intimidating, Raising voices, Repeat Phone Calls, Cursing), BY FAMILY, FRIEND OR PA TIENT IN CONNECTION WITH CONTROLLED SUBSTANCES will result in IMMEDIATE TERMINA-TION from our Controlled Substance Program
❑ 14. This pain agreement consitutes my obligations to obtain a controlled substance as dispensed by an FTN practitioner on a strictly AT WILL BASIS - there is NO RIGHT to controlled substances and any FTN practionter may AT ANY TIME AND FOR NO CLEAR REASON (and with NO OBLIGATION to provide a clear reason) suspend my controlled substance priveleges or dismiss me from the controlled substance program and I AGREE IN ADVANCE TO FULLY AGREE AND ACCEPT THEIR AUTHORITY AND DECI SIONMAKING WITHOUT CONTEST IN ADVANCE

With my signature below, I affirm that I understand all of the above and have been given an adequate chance to discuss and ask questions regarding my use of controlled substances within this practice.

Patient or Representative Signature: _____ Date: _____/_____/_____

Printed Name of Patient or Represenative: _____ If Rep, Relationship: _____