

Advanced Pain Management Institute

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

1. I am **personally** responsible for my controlled substance medications. I will take them as prescribed by my physician. If the prescription or medication is lost, misplaced or stolen, or if I use it up sooner than prescribed, I understand that it **will not** be replaced. I am aware that I must report all stolen medications to the police.
2. I **will not** request or accept controlled substance medication from any other physicians or individuals while I am receiving such medications from Dr Tarasenko. Besides being illegal to do so, it may endanger my health. The only exception is if it was prescribed while I am admitted to the Hospital.
3. Refills of controlled substance medications:
 - a) Will be made only during a **scheduled** office visit during regular business office hours 8:00am to 5:00pm , Monday through Friday.
 - b) Will **not** be made on the telephone. The telephone is not answered at night, on holidays, or on weekends.
 - c) **No exceptions will be made for patients who "run out early"**. I understand that I am responsible for taking the medication in the correct dose prescribed and for keeping track of the amount I have left. I am **not** to increase the amount or dosage of the medications without the prescribing physician's prior consent.
 - d) **Will not** be processed as an emergency, such as Friday afternoon because I suddenly realize I will "run out tomorrow". I am responsible to keep track of my medication and plan ahead. I must call at least two (2) business days ahead if I need assistance with a controlled substance prescription.
4. I am aware that under California Vehicle Code section 23152 it is unlawful to operate a motor vehicle if impaired by the effects of drugs and this includes prescribed medications. It is my **responsibility** to know the side effects of the medications I am taking and which medications may affect my ability to drive. It is also my responsibility to arrange transportation to my office visits if I am unable to drive safely.
5. I have been fully informed by my doctor about the possibility of development tolerance (the need to increase the dose of the medication to achieve the same desired effect of pain control), physical dependency on the medication, and/or addiction to controlled substances. I understand that when I stop the medications, I must do so slowly and under medical supervision or I may have withdrawal symptoms.
6. I understand that my treatment program may include some or all of the following: regular office visits, psychiatric evaluation, lab tests, physical therapy, support group or group therapy, and a drug and/or alcohol rehabilitation treatment program. I agree to participate in the treatment designed for me. I agree to be responsible for myself by complying with the doctor's plan of care. Noncompliance to the physician's plan of care may result in termination from the Center.
7. I understand that the physician may order a random drug screen to be performed right away and I understand that failure to comply with this may result in immediate termination from the clinic.
8. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment by Dr. Tarasenko may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my primary physician, local medical facilities, and other authorities.

Patient Signature: _____ Print Name: _____

Witness Signature: _____ Date: _____

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