Danny Hernandez MD, CIME

524 West Broad Street
Quakertown, Pa 18951
Phone: 215-538-6113

35 E. Elizabeth Ave. Suite 3
Bethlehem, Pa 18018
Phone: 610-419-3388

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:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

_____ 2.) Refills of controlled substance medications;

_____a) Will be made only during regular office hours *Monday through Friday, in person, once a month, and during a scheduled office visit.* Refills will not be made at night, weekends, or during holidays.

_____b)Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____c)I understand that I must call ahead within 72 hours to schedule an appointment.

_____3.) It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications will no longer be filled.

_____4.) I agree to comply with urine testing and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____5.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____6.) 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 potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____7.) I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____8.) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____8.) I understand that I will only use one pharmacy (or pharmacy brand ex. CVS, Rite aid, etc.)
Pharmacy name: _____ Phone Number: _____

I have been fully informed by _Dr. Hernandez_ regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.
Patient Signature: _____

Date: _____

Physician Signature: _____

Date:_____

<u>The office of Dr. Hernandez will be instituting the following policies effective immediately.</u>

1. All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with Dr. Hernandez
*This includes the following:

- All forms of hydrocodone – (vicodin, Lorcet, Lortab)
- All forms of oxycodone- (Percocet/percodan, oxycontin, Tylox)
- Most muscle relaxers- (valium, soma, Etc.)
- Duragesic, Fentanlyl patches
- Most sleeping agents- Ambien (Zolpidem), Lunesta,.
- All Benzodiazepines- Klonopin (clonazepam), Restoril (temazepam), Serax (oxazepam), Xanax (Alprazolam)
- Codeine Preparations (Tylenol # 3, Tussionex)
- Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)

2.) I understand that THERE WILL BE NO REPLACEMENT PRESCRIPTIONS GIVEN. NO EXCEPTION> a police report will be required to continue as a patient of the practice.

3.) I understand that I must bring all medication bottles and/or pills to every appointment for pill count verification.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature _____ Date _____

Dr. Danny Hernandez _____ Date