

STEPHEN H. MASCIO, D.O.
1417 MAIN ST
FOLLANSBEE, WV 26037
PHONE: 304-527-1670

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CONTROLLED SUBSTANCE
PATIENT RIGHTS AND RESPONSIBILITIES

PLEASE READ THE FOLLOWING CAREFULLY!
AS AN ACTIVE PATIENT AT STEPHEN H. MASCIO, D.O., IT IS MY
RESPONSIBILITY.

1. TO TAKE MY MEDICATION EXACTLY AS PRESCRIBED.
2. TO NOT INCREASE MY PAIN MEDICATION WITHOUT THE EXPRESSED
CONSENT OF MY PRESCRIBING PHYSICIAN.
3. TO NOT SHARE, GIVE, OR SELL MY PAIN MEDICATIONS TO ANYONE
ELSE.
4. TO OBTAIN MY PAIN MEDICATIONS ONLY FROM STEPHEN H. MASCIO,
D.O. I UNDERSTAND THAT IF I RECEIVE PAIN MEDICATION FROM ANOTHER
PHYSICIAN WITHOUT INFORMING STEPHEN H. MASCIO, D.O. STAFF, OR
RECEIVE NON-PRESCRIBED [ILLEGAL] DRUGS, THAT STEPHEN H. MASCIO,
D.O. WILL DISCONTINUE MY PAIN MEDICATIONS AND I WILL BE
DISCHARGED FROM STEPHEN H. MASCIO, D.O.
5. TO KEEP SCHEDULED APPOINTMENTS WITH STEPHEN H. MASCIO, D.O.
THIS INCLUDES REFERRALS FOR COUNSELING, PSYCHOTHERAPY, PHYSICAL
THERAPY, ETC. I UNDERSTAND I MUST BE SEEN IN THE OFFICE AS
SCHEDULED TO CONTINUE TO GET REFILLS ON MY MEDICATIONS.
6. TO COMPLY WITH RANDOM URINE OR BLOOD TESTING DOCUMENTING THE
PROPER USE OF MEDICATIONS AS WELL AS CONFIRMING ADHERANCE TO
TREATMENT. [THERE MAY OR MAY NOT BE A COST TO THE PATIENT FOR
THESE TESTS]. TO COMPLY WITH RANDOM BILL COUNTS AT THE DECRETION
OF STEPHEN H. MASCIO, D.O.
7. I UNDERSTAND THAT DRIVING A MOTOR VEHICLE MAY NOT BE ALLOWED
AT TIMES WHILE TAKING CONTROLLED SUBSTANCES, AND THAT IT IS MY
RESPONSIBILITY TO COMPLY WITH THE LAWS.

PATIENT SIGNATURE & DATE

PHYSICIAN SIGNATURE & DATE

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8. TO KEEP MY PAIN MEDICATION AND PRESCRIPTIONS IN A SAFE PLACE. WE RESERVE THE RIGHT NOT TO REPLACE PRESCRIPTIONS THAT ARE SAID TO BE LOST. STOLEN OR DESTROYED.

9. TO KEEP TRACK OF THE AMOUNT OF MEDICATIONS REMAINING AND TO PLAN AHEAD FOR ANY V ACTIONS OR HOLIDAYS. PHONE CALL ABOUT MEDICATIONS SHOULD BE TO STEPHEN H. MASCIO, D.O. BETWEEN 9AM TO 4PM, MONDAY THRU FRIDAY. YOU MAY NOT CALL FOR PAIN MEDICATIONS DURING ANY OTHER HOURS OR ON WEEKENDS.

10. TO CALL STEPHEN H. MASCIO, D.O. DURING REGULAR BUSINESS HOURS [MONDAY THRU FRIDAY 9AM TO 4PM] WITH ANY CONCERNS ABOUT MY MEDICATIONS OR SIDE EFFECTS OF MY MEDICATION. EMERGENCY CALLS AFTER HOURS REGARDING CONCERNS OR SIDE EFFECTS OF MY MEDICATIONS ARE ALSO ACCEPTABLE.

I UNDERSTAND THAT IT IS POSSIBLE THAT I MAY DEVELOP A PSYCHOLOGICAL DEPENDENCE [ADDITION] TO THE PRESCRIBED CONTROLLED SUBSTANCE. HOWEVER RARE, I AM READY TO ACCEPT THAT RESPONSIBILITY. IT IS ALSO POSSIBLE TO DEVELOP A TOLERANCE WHICH IS THE NEED TO INCREASE THE DOSE OF THE MEDICATION TO ACHIEVE THE DESIRED EFFECT. IF A PRESCRIBED CONTROLLED SUBSTANCE IS GIVEN LONG TERM A PHYSICAL DEPENDENCE TO THE MEDICATION MAY OCCUR THEREFORE, IF THE MEDICATION NEEDS TO BE STOPPED IT MUST BE DONE SLOWLY AND UNDER MEDICAL SUPERVISION TO AVOID WITHDRAWAL SYMPTOMS. I AGREE TO COMPLY WITH THE PROPOSED TREATMENT PLAN AND UNDERSTAND THAT MY TREATMENT MAY CHANGE THROUGHOUT MY TIME AS A PATIENT AT STEPHEN R MASCIO, D.O.

11. TO USE ONE PHARMACY ONLY TO FILL MY PRESCRIPTIONS.
PHARMACY NAME: _____

PATIENT SIGNATURE & DATE

PHYSICIAN SIGNATURE & DATE

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12. I UNDERSTAND THAT ANY BELLIGERENT, DISRUPTIVE, OR DISRESPECTFUL BEHAVIOR TOWARDS ANY STAFF MEMBER AND/OR STEPHEN H. MASCIO, D.O. IS GROUNDS FOR DISCHARGE.

BY SIGNING THIS CONTRACT, I AM AGREEING TO ALL OF THE ABOVE TERMS. I UNDERSTAND THAT FAILURE TO COMPLY WITH ANY OF THEM MAY JEOPARDIZE THE PHYSICIAN-PATIENT RELATIONSHIP, AND MAY ULTIMATELY RESULT IN MY DISCHARGE FROM STEPHEN H. MASCIO, D.O.

PATIENT SIGNATURE & DATE

PHYSICIAN SIGNATURE & DATE