Adult Neurology Center, P.C.

Bruce M. Cotugno, M.D. ◊ Kent E. Berkey, M.D. ◊ Evgeniy A. Shchelchkov, M.D.

1025 Jefferson Avenue
Washington, PA 15301
(724) 229-6195

1900 Waterdam Plaza, Building 3, Suite1
McMurray, PA 15317
Fax (724) 229-6199

Consent to Treatment Addendum

Driving Privileges:

The Motor Vehicle Code of Pennsylvania requires physicians, certified nurse practitioners, and physician assistants, when conducting physical examinations, to exercise their judgment and report certain medical conditions of a patient to the medical unit of the Department of Transportation, if in the opinion of the examiner that patient should be reported as having a medical condition affecting the ability of the patient to drive safely. We must comply with this state requirement. Medical conditions disclosed or apparent to us which may prompt notification to the state include, but are not limited to; periodic loss of consciousness, mental deficiencies, drug use, epilepsy, and vision problems.

- -

Prescription Narcotics Agreement:

Our practice takes the law very seriously, especially as it pertains to controlled substances. This agreement was created to prevent misunderstandings about medications that you may be taking for pain management. It is to help you and the doctor comply with the laws regarding controlled medications.

♦ I understand that if I break any condition of this agreement, my doctor will stop prescribing the medication. I also realize that this non-compliance could lead to dismissal from the practice

♦ I agree that any controlled narcotics prescribed by my doctor in this office will only be refilled through this office and I will not seek or obtain opioid prescriptions from another physician or emergency care center while under the care of my physician.

♦ I agree to use ____Pharmacy, located at _____________________________________
(Pharmacy Name)

____ for all of my pain medication.
(Pharmacy Address / Phone Number)

♦ I agree that refills of my prescription for pain medication will be made only at the time of an office visit or during regular office hours. I understand that no refill on narcotic medication is available in the evening or on weekends.

♦ I will inform this doctor of all other medications that I am taking.

♦ I agree to take the pain medication at the dose prescribed by my doctor and that using my medication at a greater rate will result in my being without this medication for a period of time.

♦ I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else.

♦ I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.

♦ I agree to urine testing to assure medication compliance that will be randomly ordered by my prescribing doctor, as well as pill counts to be requested at the physician's request. I agree to submit for testing under any timeframe my doctor requests.

♦ I understand that the use of mood altering substances such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin, or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.

____ __________________________
Printed Patient's Name Date of Birth

____ __________________________
Patient's Signature Today's Date