

Ardavan M. Aslie, M.D.

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AGREEMENT FOR PRESCRIPTIONS

1. **I am responsible for my medications.** 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 stolen medications to the police.
2. **I will not request or accept a controlled substance medication from any other physician or individual while I am receiving such medication from Dr. Aslie.** I am aware that it would be illegal to do so and also may endanger my life. The only exception is if it is prescribed while I am admitted in a hospital.
3. **Refills of medication will be made only during regular office hours Monday through Thursday 8:00 a.m. to 5:00 p.m.** Refills will not be made at night, on holidays, on Fridays, on weekends, or on an emergency basis. The patient is responsible for maintaining an amount sufficient for at least 48 hours of treatment. Please call the office 48 hours in advance to allow for sufficient time to process a prescription for a controlled substance.
4. **I am aware that under California Vehicle Code Section 23152 it is unlawful to operate a motor vehicle under the influence of drugs and alcohol and this includes prescribed medications.** It is my responsibility to know the side effects of the medications I am taking and which medication may affect my ability to drive. It is also my responsibility to arrange transportation to my office visits if unable to drive safely.
5. Dr. Aslie has prescribed a pain medication or made a change in my pain medication prescription. I am aware that I need to **STOP TAKING ALL OTHER PAIN MEDICATIONS IMMEDIATELY BEFORE TAKING THIS PRESCRIPTION.**
6. I have been fully informed by Dr. Aslie and/or his staff about the medications prescribed to me.

NAME: _____

SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____