Medication Usage Agreement  
New 10/18

Patient or Caregiver (responsible party) by signing below acknowledges understanding and agreement with the following statements:

I understand and agree I am solely responsible for the medication(s) entrusted to me and in my possession.

I understand and agree High Peaks Hospice (HPH) nurses will be allowed complete and immediate access to all medication(s) in my possession and will be allowed to count these medication(s).

I understand and agree the medication “counts” must indicate the medication(s) are being taken only as prescribed and there will be no missing or unaccounted medication(s).

I understand and agree, if the medication(s) “count” indicates medication(s) are missing or deemed unaccounted for, I understand I (the patient) will cause the discontinuation of narcotics/controlled substances provided by HPH.

I understand and agree to report any and all medications obtained from any other physicians.

I understand and agree (caregiver/responsible party other than patient) refusal to comply with the terms of this Medication Usage Agreement will cause the discontinuation of narcotics/controlled substances provided by HPH.

I understand and agree (caregiver/responsible party other than patient) refusal to comply with the terms of this Medication Usage Agreement will cause the possible discharge for cause from HPH.

I understand and agree if medication(s) are deemed to be unaccounted for or missing, a report to HPH nurse and legal authorities such as the police will be initiated.

I acknowledge understanding and agree to the above by signing:

<table>
<thead>
<tr>
<th>Patient Name/Responsible party (Print)</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Signature of Patient and/or Responsible party</td>
<td>Date</td>
</tr>
<tr>
<td>Hospice Representative Signature (witness)</td>
<td>Date</td>
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