# Controlled Substance Use Agreement

*The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.*

I, ______________________________, understand that I have a medical condition, _________________, that requires use of controlled substance medication(s) because this medical condition has not been adequately controlled with non-controlled medications and that my function is limited by this medical condition. I understand that the intent of this medication is to increase my ability to do more, though the controlled substance medication is unlikely to eliminate my condition.

I will take the medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my doctor.

I understand that the medication will be prescribed only by Dr. ______________ and only according to the agreed upon schedule. Prescriptions will be provided only during regular business hours. Medications will not be called in to the pharmacy.

I will not seek or accept any additional controlled substance medications (i.e. pain, anxiety or stimulants) other than those prescribed by my doctor. This includes prescriptions from other doctors, medications borrowed or accepted from family or friends and any illicit or street drugs.

Medication refills will be given no sooner than every 30 days. I understand that I must make appointments with my doctor at least every (1) month or sooner if my doctor recommends. No refills will be given if I do not keep these appointments. Two (2) no show appointments will constitute grounds for immediate dismissal from the practice.

I understand that my doctor is under no obligation to provide these medications to me, and that he/she reserves the right to discontinue these medications at any time. If I refuse, I understand the medications will be stopped.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure my medications. This includes keeping the

Patient Initials: ________ Provider Initials: ___________

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medication out of reach of children. A copy of a police report will be required for any lost or stolen controlled substance prescriptions.

I understand that my doctor is required by law to report all controlled substances dispensed to me to the state monitored prescription monitoring program.

In addition to the above agreements, I accept the right of my doctor's staff to terminate this agreement for any of the following reasons:

a) I seek or obtain any controlled medication from a source other than my doctor.
b) I in any way attempt to forge or alter a prescription.
c) I distribute my prescribed medication(s) to any other person.
d) My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents danger to my well being or safety.
e) There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and immediate dismissal from my doctor and the practice.

I understand that if I default from this agreement and I am having a medical emergency I should call 911 or go to the nearest emergency room.

Patient Name: (printed) ______________________________________________
Patient Signature: _________________________________________________
Date Signed: _______________________ Date of Birth: ____________________

Provider Signature: ________________________________________________
Date Signed: _______________________