Matthews-Vu Clinic
4190 E Woodmen Road
Suite 100
Colorado Springs CO, 80920

Provider-Patient Agreement for Controlled Substances

I, ____ understand that I must comply with and adhere to the following conditions to receive my controlled medications.

1. I will obtain all my controlled substances from the provider whose signature appears below or, during his or her extended absence, by the covering provider.

2. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for the purpose of maintaining accountability.

3. If the responsible legal authorities have questions concerning my treatment, as might occur, such as if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substance administration.

4. I agree to use my medication only as directed.

5. I will not increase, decrease, or abruptly stop taking my medication without my provider's knowledge and permission, because doing so may cause risk of harm and withdrawal.

6. I understand I can only receive controlled medication refills at scheduled appointments or as discussed with my provider. I agree to schedule an appointment as directed by my provider for the purpose of renewing my prescriptions and assessing my progress.

7. I understand that early refills will not be given.

8. I will let my provider know at least 7 days before my refill is due to give reasonable notice.

9. I understand that my prescriber is not responsible for drug supply shortages, or insurance coverage refusal.

10. Medications may not be replaced if lost, destroyed/damaged, or stolen. Stolen medications with a completed police report may or may not be refilled at my Provider's discretion. My provider may consider replacing lost, misplaced, or stolen controlled medications only at an appointment.

11. I understand that it is my responsibility to schedule a more urgent appointment if I begin to experience any problems associated with my controlled medications, or if other medical conditions arise that may be affected by my medication.

12. I am expected to inform my provider of any changes to medications or medical conditions, including by outside providers/clinics, and of any adverse effects I experience from any of the medications I take.

13. I am aware of the risks of concurrent alcohol use. I will not use illegal substances while taking my controlled medication. I will also disclose any current drug use (including Marijuana) to my provider.

14. I understand that my provider has the right to screen me for substance use at their discretion, and that refills may be contingent on sobriety and lab results.

15. I will not sell or share my controlled medications, allow others to use my medication, alter my medication prescriptions, or use my medications in any unintended ways. I will keep my medications safely stored away from others.

16. I will notify my provider if I am not on birth control, intend on becoming pregnant, or become pregnant.

17. I understand that my provider may choose to discontinue my controlled medication if they believe that my condition is not improving, my medication usage is no longer recommended, my functional ability is not increasing, or if I begin to experience unacceptable side effects.

18. The risks and potential benefits of these therapies are explained to me [and I acknowledge that I have received such explanation].

19. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all its terms and conditions.

I understand the risks and benefits of taking these medications and agree to the terms above.
Failure to adhere to the above policies may result in cessation of my controlled medicine prescription by this provider, referral for further specialty assessment, or termination from the practice.

Patient/Guardian Name:	DOB:
Patient/Guardian Signature:	Date:
Provider Signature:	Date: