Patient Agreement for Controlled Substance Prescriptions

NAME_____ DATE OF BIRTH_____

The following agreement is for the purpose of establishing agreement between Patient and Provider on clear conditions for prescribed controlled substance medications.

Please initial each statement and thoroughly review the following conditions:

_____ I am aware of the potential risks associated with use of such medication including, but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, , slowing of breathing rate, slowing of reflexes, physical dependence, tolerance to pain medications, addiction and the possibility that the medicine will not provide complete relief of symptoms.

_____I understand the treatment goal at hand is to reduce pain and improve ability in daily functional activities and responsibilities. I will participate in other treatment alternatives if my provider suggests. I agree to help myself improving my overall health as much as possible through appropriate exercise, weight control, avoidance of tobacco and alcohol, etc.

_____ I am responsible for safeguarding the controlled substance. This includes safeguarding from other family members and ensuring it is out of reach of children

_____ I will not share, sell or trade my medication for money goods or services. I understand that if I do, my treatment will stop.

_____ I understand that if my prescription is lost, misplaced, damaged, or stolen, it will not be replaced. I understand I will be without my prescribed medication for a period of time. I will not call between appointments, at night or on the weekends, looking for refills. I understand that prescriptions will be filled only during scheduled office visits.

_____ I will make sure I have appointment for refills. I will keep (and be on time for) all my scheduled appointments with the doctor.

_____ I will not attempt to get pain medication from any other Healthcare Provider without approval from my own provider or, without telling the other Healthcare Provider that I am taking the controlled medication prescribed.

_____ I will take my medication as instructed and not change the way I take it without first consulting with the doctor or other member of the treatment team.

_____ I agree to comply with random urine, blood, or breath test to confirm proper use of my medications.

_____ I will not use any illegal substances including marijuana, cocaine, etc.

_____ I understand that insurance may not cover the medication, appointment, or associated testing. If the insurance declines payment I will be responsible for payment.

_____ I agree to use only one pharmacy to refill medication. If I change my pharmacy for any reason, I agree to notify my Provider immediately with updated pharmacy information. I agree to use pharmacy/phone number: _____

I have thoroughly reviewed and voluntarily agree to this contract. I understand if my behavior is inconsistent, inappropriate, or in violation to any of the above conditions, I understand the provider may stop prescribing the medication or I may be terminated from this clinic.

_____	_____
(PATIENT NAME)	(PRESCRIBING PROVIDER NAME)
_____	_____
(PATIENT SIGNATURE)	(PRESCRIBING PROVIDER SIGNATURE)
_____	_____
(DATE)	(DATE)