Controlled Substance Agreement Form

Patient Name: _____

Medical Record Number: _____Date of Birth: _____

I, _____, understand that in order to receive care for the treatment of pain or the use of controlled medications, I agree to and will comply with the following: (Initial that you have read each section)

____A. **MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT**: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the undersigned physician. If you are on any mental health prescriptions you will have to have a recent (within 3 months) psychological evaluation done before any narcotics are given.

____B. **USE OF MEDICATIONS**: I will take all medications as prescribed. I will speak with the undersigned physician before making any change in either the dose or frequency of my medications. **There will be no early refills of controlled medications due to you increasing your dose or frequency.** I will abstain from alcohol use while taking pain medications.

____C. **PHARMACY**: Narcotic pain medications must all be obtained from the same pharmacy each time (any exception must be approved by the undersigned physician).

Pharmacy Name: _____

Location of Pharmacy: _____

____D. **SEEKING PRESCRIPTIONS**: **I will neither seek nor fill prescriptions for any controlled medication from any other health care provider. I will not harass or repeatedly speak with the pharmacist about refills which may be early. I will not call the physician after hours about my controlled substance prescription refills. I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.**

____E. **MEDICAL RECORDS RELEASES**: I will inform all of my health care providers that I receive pain management and will maintain an unrestricted and current medical records release on file.

____F**. DRUG SCREENING**: I will participate in drug screening as a part of my treatment plan. I understand that urine drug screening will be conducted on my first visit before any controlled substances will be prescribed and thereafter on a random basis when requested by the treating physician. Screening may include urinalysis, blood testing, mouth swab or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Specimens will be sent to Lab for final results.

Additional charges may occur from the Lab Facility. Refusal to submit to screening at the time specified may result in termination of services.

____G. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that the use any controlled medication not prescribed by the undersigned physician may result in termination of care. I authorize the practice to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines. I authorize the practice to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance, including marijuana as well as alcohol may result in termination of care.

____H. **LOST OR STOLEN MEDICATIONS**: I agree to safeguard all medications prescribed by the undersigned physician and understand that **lost, stolen or damaged medications will not be replaced**. **This includes paper form prescription as well as pills in bottle**. I will keep the **medicine safe, secure and out of the reach of children**.

____I. **PRESCRIPTIONS PRESCRIBED BY OUR PROVIDERS**: **You must bring in all prescription bottles with medication in them that are prescribed by our office at every visit**. Please expect a pill count to be performed at each visit and random pill counts to be requested when applicable.

____J. **DRIVING & OPERATING EQUIPMENT**: Many medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy. I am aware that I am not to drive while under the influence of narcotics even if prescribed by physician.

____K. **TERMINATION:** I will no longer be eligible for care if I am in possession of illicit drugs or substances, trafficking in controlled or illegal substances, intoxicated or if arrested for DUI. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for care. If I do not report for a requested pill count within 24 hours of the request, I will no longer be eligible for pain management care.

____L. **USE OF LEGALIZED THC:** The Opioid medications that are prescribed have many interactions with both prescribed and non-prescribed medications. Due to these interactions, patients who have been prescribed Legalized THC will need to maintain a very low to non-detectable level of THC in their urine drug screenings. Our pain management providers reserve the right to not prescribe a Controlled Substance medication or other type of pain medication if the level of THC is too high in a urine drug screen.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN TERMINATION OF THIS CONTRACT AND DISCHARGE FROM PHYSICIAN AND/OR PRACTICE.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date