Controlled Substance Prescription Agreement

Many patients will require the use of medications to help manage their pain to an acceptable level. These medications have risks and side effects. In addition to what is mentioned below your doctor will discuss these with you. You will need to understand and comply with what is outlined in this agreement in order for medications to be continues. It is unreasonable to expect complete relief of symptoms with medications. Our Goals is to provide medications that will help to make the pain Tolerable. If we take over the prescribing of your pain medications, you will be required to complete the medication management agreement below.

☐ 1. You are responsible for your medication if the medication is lost, misplaced, or stolen, or if it is used up sooner than prescribed. It will not be replaced or refilled. You must report stolen medications to the police, and the police report must be given to the physician in order for a replacement prescription to be given to you.

☐ 2. You may NOT except or request pain medication from another physician without consulting with your doctor here. This may confuse your medical care, but it may also endanger your health. The only exception is medication given to you while you are in the hospital or emergency room.

☐ 3. This medication may affect judgment and driving ability. Most mental effects of these medication are minimal after one week of use of a stable dose. You are responsible for judging the medication's effect on you coordination and judgment before making any important or legal decision and before operating a motor vehicle or power machinery.

☐ 4. You are responsible for being compliant with your medication recommendations. This means that Missed appointments or failure to follow up with your doctor's orders, may be viewed as the pain medication's interfering with your judgment and memory. In this case the medication will likely be stopped.

☐ 5. Refills will only be made during regular business/clinic hours. Refills will not be made on the days the clinic is not open. Refills will only be given during scheduled appointment time. The need for other times may reflect the medication's effect on memory or judgment, which could mean over sedation. This may result in the medications being stopped.

☐ 6. Refills will NOT be made is you "run out early" nor will they be made on an emergency basis. You must keep track of your medication and call at least 72 hours in advance if you need assistance with your medication. If you anticipate running out of your medication before your next appointment or if you will be leaving town and need medication, YOU are responsible for contacting the clinic during regular clinic hours to obtain the necessary prescription. Failure to do so will be interrupted as the medication's affecting your memory or judgment and it will likely be discontinued.

☐ 7. Please be aware that, as part of your treatment plan, Random Urine or Blood Sampling will occur. The identification of urine prescribed medications or illicit substances may result in termination of your patient care.

If you failed to comply with all of the above conditions, it is likely that your physician will discontinue the pain medication. If the violation involves the selling of medications or obtaining medications from a physician, you may be reported to other physicians and authorities.

The purpose of the medication is to help you function better both at home and at work. If there I evidence that the medication is not achieving this goal, your physician will likely discontinue the medication.

Pain medication can produce psychological dependence (addiction) and/or physical dependence. Although Psychological dependence is rare you must understand those physical dependence is more frequent risks which will be discussed with you by your doctor. This means that the medication may need to be stopped slowly; suddenly stopping may produce withdrawals symptoms. Tolerance can also occur with these medications, meaning that their effects over time may diminish or stop completely.

Your signature below indicates that you have read and understand that above information and that you will follow doctors' instruction regarding the medical treatment/plan.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Witness Signature