

## **CONTROLLED SUBSTANCES AGREEMENT**

I, \_\_\_\_\_, a patient of Dr. \_\_\_\_\_ **[PHYSICIAN PRACTICE/PROVIDER]**, have been informed that individuals who are prescribed certain controlled substances including, but not limited to, narcotic pain medicines, stimulants, benzodiazepine tranquilizers, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat my pain.

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
2. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substances will be prescribed to me. I agree that the need to be evaluated by psychologists and/or psychiatrists may be revisited every three (3) to six (6) months thereafter while taking the medication.
3. All controlled substances must come from a physician in **[PHYSICIAN PRACTICE/PROVIDER's]** office. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific written authorization is obtained from the office for an exception.
4. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform the **[PHYSICIAN PRACTICE/PROVIDER's]** office.
5. I will inform the **[PHYSICIAN PRACTICE/PROVIDER's]** office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
6. I will inform my other health care providers that I am taking the controlled substances listed above, and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.
7. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.

8. I will not allow anyone else to have, use sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is against the law.
9. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
10. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
11. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
12. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.
13. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by a **[PHYSICIAN PRACTICE/PROVIDER]** physician.
14. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
15. I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication by **[PHYSICIAN PRACTICE/PROVIDER]**. Failure to comply may result in immediate discharge from the practice.
16. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.
17. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report or a statement from me explaining the circumstances may be required before additional prescriptions are considered. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, I may be discharged from the practice.
18. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.
19. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, all

confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

20. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.
21. I understand that I may be asked to bring my medications in their original container to the **[PHYSICIAN PRACTICE/PROVIDER's]** office while I am on controlled medication.
22. Refills generally will not be given over the phone, after office hours, during the weekends, and on holidays.
23. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by my physician at **[PHYSICIAN PRACTICE/PROVIDER]**.
24. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage.
25. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.
26. I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician Name (printed)

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date