**Controlled Substances Agreement**

This agreement is made to prevent any misunderstanding regarding your prescriptions for controlled substances and to comply with the laws governing controlled pharmaceuticals. Please read and initial each line below.

\_\_\_\_ I understand that this agreement is essential to the trust and confidence that is necessary between patient and provider.

\_\_\_\_ I understand that any breach of this agreement will prevent my provider from prescribing any further controlled substances in the future and could possibly lead to my being discharged from the practice.

\_\_\_\_ If my provider decides that I should seek treatment with counseling, psychiatric treatment, psychotherapy, and/or psychological treatment I will be amenable to that.

\_\_\_\_ I will always communicate fully with my healthcare provider about the type and intensity of symptoms that my medication has been prescribed for, including discussing how well the medication is at relieving those symptoms.

\_\_\_\_ I will not use ANY illegal controlled substances, including, but not limited to marijuana, crack/cocaine, methamphetamine, etc. I will also not misuse or self-medicate with legal medications/controlled substances.

\_\_\_\_ I will ensure that my controlled substances are not used concurrently while drinking alcohol, driving, operating machinery, or anything else that might impair my abilities.

\_\_\_\_ I will not share or sell my medication with ANYONE under any circumstances.

\_\_\_\_ I will not seek out any other controlled medications from other providers without the knowledge and consent of my current provider.

\_\_\_\_ I will keep my controlled medications stored safely to prevent any theft or loss of them, and I understand that if any medications are lost or stolen they will NOT be replaced.

\_\_\_\_ I agree that refills of my prescriptions will not be made over the telephone, on weekends, or after hours. I will keep my appointments for follow up at no longer than 3-month intervals.

\_\_\_\_ I give express consent for my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the states Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medications. My provider will be authorized to comply with any request for this agreement from any applicable pharmacy, emergency room, or alternate health care provider. I am agreeing to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

\_\_\_\_ I agree that I will use one pharmacy for filling-controlled substances. My pharmacy will be \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_ I agree that if my provider requests a blood, hair follicle, or urine test to determine compliance with my controlled medications I will comply with this request.

\_\_\_\_ I agree that I will only use my medication at the prescribed schedule and if it deemed that I have used it with a different schedule I could potentially be without my medication until the next available refill.

\_\_\_\_ I understand the side effects related to use of controlled substances included, but not limited to chemical dependence, drowsiness, nausea, slowed respirations, palpitations, chest pain, difficulty urinating, and constipation. I am also aware that taking medications more than prescribed can increase these risks and result in potentially dangerous or life-threatening situations.

\_\_\_\_ Females: I agree that I am not currently pregnant or breast feeding and that I will inform my provider if I plan to become pregnant or immediately upon becoming pregnant.

\_\_\_ I agree to follow these guidelines as they have been fully explained to me and all my questions or concerns have been addressed and answered. I also have been given a copy of this document.

This agreement is effective beginning on this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient Name (written): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_