CONTROLLED SUBSTANCE AGREEMENT

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:

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.

B. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with the undersigned physician/nurse practitioner before making any change in either the dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Narcotic pain medications must all be obtained from the same pharmacy each time (any exception must be approved by the undersigned provider). I will abstain from alcohol use.

C. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medication from any other health care provider unless authorized by the providers in the practice. I will not harass or repeatedly speak with the pharmacist about refills which may be early. I will not call the provider after hours about my controlled substance prescription refills.

D. 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.

E. DRUG SCREENING: I will participate in drug screening as a part of my treatment plan. I understand that drug screening may be conducted at least every 12 months and may be required more frequently at the discretion of the undersigned provider. Screening may include urinalysis, blood testing and/or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of services. The Downtown Doctor does not discriminate; we drug screen all patients for whom we prescribe chronic narcotics or any controlled substances.

F. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use any controlled medication not prescribed by the practice 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, may result in termination of care.

G. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by the undersigned provider and understand that lost or damaged medications will not be replaced.

H. PRESCRIPTIONS WHILE TRAVELING: The practice may provide prescriptions for up to 90 days when patients are traveling out of state. Patients will have to arrange for shipment of controlled substances by their pharmacy at their own expense. Patients who will be out of state longer than 90 days need to arrange for health care at their travel destinations.

I. 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.

J. OTHER RESTRICTIONS AND/OR CONSIDERATIONS:

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.

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 IMMEDIATE TERMINATION OF SERVICE.

_____

Patient Signature and Date

_____

Medical Care Provider; Signature and Date