Main Family Medical

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Controlled Substance Agreement

Patient Name: _____ Date of Birth: _____

1. I understand that my provider and I will work together to find the most appropriate treatment for my condition of ADHD/pain/anxiety/insomnia. I understand that the **goals of treatment are not to completely eliminate my symptoms but to reduce them** in order to improve my ability to function. Continuing a prescription is contingent upon evidence of its benefit.
   Please initial showing that you have read and understand above: _____

2. I understand that my provider and I will continually evaluate the effects the controlled substances have on achieving the treatment goals and understand that adjustments may be needed. I agree to come in for re-evaluation and possible adjustment if the dose is not sufficient to adequately control symptoms. I will not stop the medication abruptly unless having side effects and/or allergic reactions.
   Please initial showing that you have read and understand above: _____

3. I understand that the use of other medications can cause adverse effects or interfere with medication therapy. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, tranquilizers and all illicit drugs. I understand that I should not be using the above substances while on opioid medication supplements.
   Please initial showing that you have read and understand above: _____

4. I agree to comply with random urine screenings every 6-12 months and/or as deemed necessary by my PCP. I understand that failure to comply may lead to discharge from the practice.
   Please initial showing that you have read and understand above: _____

5. I understand that **any change in my medication treatment plan will not be made over the phone**, and it will require a follow-up visit for re-evaluation. I also understand that prescriptions will not be changed without me returning the rest of my original prescription to the office for identification, counting and destruction by my provider, and returned to me for disposal.
   Please initial showing that you have read and understand above: _____

6. **I agree to take the medication at the dose and frequency prescribed by my provider**. I agree not to increase the dose of opioids or controlled substances on my own, and understand that doing so may lead to my treatment with opioids and/or controlled substances being stopped.
   Please initial showing that you have read and understand above: _____

7. **I understand that if my prescription runs out early for any reason (for example, if I take more than is prescribed or I lose the medication) my provider will not prescribe extra medicine for me. I will have to wait until the next prescription is due**, even if this means my going through withdrawals. I also understand that going through withdrawals is uncomfortable, but not life threatening.
   Please initial showing that you have read and understand above: _____

8. **I understand that prescriptions take at least 5 working days to refill** and will plan accordingly if a prescription is due on a weekend or holiday. **Same day requests or walk-in requests will NOT be honored or filled**.
   Please initial showing that you have read and understand above: _____

9. **I understand that requests for renewals and refills will be handled Monday through Friday between the hours of 8am and 5pm.** No refills or adjustments will be made after business hours. I understand that there will be no refills after hours by any of our on call physicians or providers for any reason. I understand that the on-call providers are called for emergencies only.
   Please initial showing that you have read and understand above: _____

10. I will not seek controlled substances from any other medical provider (MD, DO, PA, NP, Dentist, etc.), emergency rooms, urgent care facilities, or any other persons or medical facilities.
    Please initial showing that you have read and understand above: _____

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11. I understand that common potential side effects of opioid therapy include constipation, nausea, sweating, itching/rash, and allergic reactions. Since many controlled substances may be hazardous or lethal to a person who is not tolerant to their effect, especially a child, I will keep them safely out of reach of other people. I recognize that if I come off my medications, I may lose my tolerance to them, and I will not restart my previous prescription without discussing this with my physician/provider. Drowsiness may occur when starting medication or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating machinery until such drowsiness disappears.
    Please initial showing that you have read and understand above: _____

12. I understand that I may become dependent on controlled substances, which in a small number of patients may lead to addiction. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If addiction occurs, the medication will be discontinued and I will be referred to a drug treatment program for help.
    Please initial showing that you have read and understand above: _____

13. I understand that running out early, needing early refills, escalating dosages without permission and losing prescriptions may be a sign of misuse of the medication and can be a reason that the provider would discontinue prescribing to me.
    Please initial showing that you have read and understand above: _____

14. I will not give, lend or sell my medication to anyone else, including my family members; nor will I accept any opioid, stimulant, sleep hypnotic, benzo or pain medication from someone else.
    Please initial showing that you have read and understand above: _____

15. I agree that I will attend all appointments, treatments and consultations as required by my providers. Failure to do so may cause termination of opioid or controlled substance treatment plan. I understand that if I cancel or “no show” to three appointments, that my future services may be discontinued.
    Please initial showing that you have read and understand above: _____

16. If I become pregnant I will notify my Physician or provider immediately. If I am pregnant and on controlled substances, I understand that it is likely that my child will be born physically dependent on the medications I am receiving.
    Please initial showing that you have read and understand above: _____

17. **I understand that only the patient may pick up the prescriptions unless special arrangements have been made**. The staff will ask for picture identification, and will not release any prescription without it.
    Please initial showing that you have read and understand above: _____

18. I hereby agree that my provider has the authority to discuss my pain management and this contract with other healthcare professionals and my family members when it is deemed medically necessary in the provider’s judgment. If the legal authorities have questions concerning my treatment as might occur for example, if I am obtaining medications at several pharmacies, these authorities may be given full access to my records.
    Please initial showing that you have read and understand above: _____

19. I will use **only one pharmacy**. Should the need arise to change pharmacies, our office must be informed.
    The pharmacy you have selected is: _____

I have read the above and have been given opportunity to discuss my questions with Main Family Medical’s staff. I understand that failure to adhere to this agreement will result in some or all of the following as deemed necessary by the treatment team: medication taper; discharge; chemical dependency evaluation/treatment; and notification of Pharmacy Board of the State of Idaho, personal pharmacy, referring and treating physicians, ER/Urgent Care Centers in the surrounding community, and my insurance company.

_____	_____	_____
Patient Signature	Date	PCP