Controlled Substance Agreement

The purpose of this Agreement is to prevent misunderstandings and to establish guidelines for controlled substances prescribed between the provider and patient to help both parties comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my provider may stop prescribing my controlled medicines and may terminate me from Satellite Med.

I will communicate fully with my provider about the character and intensity of my condition(s), the effect on my daily life, and how well the medicine is helping in my treatment plan.

Female Only- I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my provider if I believe I may be pregnant. I agree not to take any medication without approval if I become pregnant.

I will not use any illegal controlled substances (including marijuana, cocaine, heroin or other illegal substances).

I will not share, sell, or trade my medication with anyone. I will bring all unused medicine to every visit.

I will not attempt to obtain any controlled medicines, stimulants, or anti-anxiety medicines from anyone else.

I will safeguard my medicine. NO allowance will be made for lost or stolen medicine/prescriptions.

I agree that refills of my prescriptions will be made only during regular office hours. No refills will be available during evenings or on weekends. Prescription requests may take up to 48 hours to complete. Patients are required to have an appointment for controlled substance refills; no same day appointments allowed.

I understand that my primary care provider needs to prescribe the medication(s). In the event my primary care provider, _____, is unavailable, any refills authorized by another Satellite Med provider will follow these guidelines:

Name of Provider

- Prescriptions will not exceed 30 days
- No dosage or frequency adjustments may be made

I agree to use ONLY the following pharmacy for filling prescriptions of all my controlled medicines:

_____

Print Pharmacy Name Address Phone number

I authorize the provider and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medication. I authorize my provider 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 agree that I will submit to random drug testing, at my expense, to determine my compliance with my program. I agree to enter a drug treatment program if my provider recommends it.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine in a greater rate may result in death and will result in my being without medications for a period of time.

I agree to follow this and other advice given by my healthcare provider or pharmacist. If the medication prescribed causes an adverse reaction, I will discontinue the medication immediately and notify my provider.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 20_____.

Patient Name (printed): _____Signature:_____

Provider Signature:_____ Witnessed By:_____