Controlled Substance Agreement

HCA Healthcare | Physician Services Group

PATIENT NAME:_____ **DOB**:_____

The purpose of this Agreement is to enter a mutual agreement regarding certain medicines (controlled substances) you will be taking or could be taking in the future. Prescription of controlled substances is strictly monitored by state and federal law so strict accountability is necessary.

Patient Responsibility

1. **I understand that this Agreement is based on the trust and confidence** necessary in a provider/patient relationship and that my provider will manage controlled substances based on this agreement.
2. **I understand that if I break this Agreement**, my provider will stop prescribing these controlled substances.
3. **I agree to notify my provider** of any and all controlled substances or prescriptions that I receive from other providers. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or benzodiazepines/hypnotics medicines from any other provider unless that provider is co-managing care with my current provider.
4. **I agree to consider to follow my provider's recommendation** to seek psychiatric treatment, psychotherapy, psychological treatment or referral to pain management specialist / addictionologist if my provider deems necessary.
5. **I understand that someday my provider may recommend weaning me partially or totally from controlled substances** and that he/she may suggest a new treatment plan or discuss pursing other treatment options. Abruptly stopping certain medications can cause serious risk to my health and that weaning instructions must be followed explicitly.
6. **I understand that controlled substances have potential risks and side effects**, **including the risk of addiction.** An over-dosage with a controlled substance may cause injury or death. I also understand that controlled substance may impair my ability to drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy and subject me to regulations concerning driving while under the influence of drugs for which I am responsible in adhering to those regulations. (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this/these medication, I will immediately inform my obstetric provider and prescribing provider.
7. **I understand that controlled substances can interact with other medications.** I will not use any recreational mind-altering or illicit (i.e. marijuana, cocaine, methamphetamine, etc.) substances. I will inform my provider of ALL current medications including herbs, vitamins, supplements, and over-the-counter medications. I understand the combination of opiates or pain medications with benzodiazepines/hypnotics or CNS depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death.
8. **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed.** I will take my medication whole; my medication will not be broken, chewed, crushed, injected, or snorted.
9. **I agree that I will use my medicine as prescribed** and that use of my medicine at a greater rate will result in my being without medication for a period of time and possible termination of care. I will avoid withdrawal symptoms by taking as directed, not taking more medications than prescribed, and keeping my appointments for refills. I understand that 'running out' of medication is not grounds for insisting on an 'emergency or urgent appointment'.
10. **Any change in dosage must be approved by an Austin Brain & Spine provider. I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law. Forged prescriptions and/or forged provider's signatures are also against the law.** If any of these instances occur, it will result in an immediate termination from this practice and report to local authorities.
11. **I agree that refills of my prescriptions** for controlled substance will be made only at the time of an office visit or during regular office hours and not earlier than the agreed renewal date. No refills will be available during evenings or on weekends or by phone.
12. **I will safeguard my controlled substances from loss or theft and will not share, sell or trade my medication with anyone nor will I take other individual's prescribe CS**. I understand that if I am suspected of diverting or

distributing my controlled substances, my provider will immediately cease prescribing these medications and will likely be cause for dismissal from the practice. In this case, my provider will be required to comply with local state and/or federal reporting requirements and investigation. Lost or stolen medicines will not be replaced.

13. **I authorize the provider/practice** if directed by law enforcement agencies 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 my pain medicine or other controlled substances. If requested, I authorize my provider to provide a copy of this agreement to my pharmacy or to the requesting government agency. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
14. **I agree that I will submit to a blood or urine test** if requested by my provider to determine my compliance with my program of controlled substance. Tests may include screens for illegal substances, and my cooperation is required. Refusal of such testing may subject me to an abrupt / rapid wean schedule in order for the medication to be discontinued or prompt termination from this practice.
15. **I will bring** all unused controlled substances when requested by my provider.
16. **I agree to abide to the Practice's Patient Rights and Responsibilities and understand that any serious misbehavior** such as yelling, threatening, cursing, etc. will likely be cause for dismissal from the practice.

Provider/Practice Responsibility

1. **We will provide the best evidence based care** for your condition.
2. **We will help** set functional and pain control goals with you.
3. **We will assess and discuss** with you the risk/benefit/safety of your medications.
4. **Before writing any controlled substance prescriptions**, we will check the state prescription monitoring database.
5. **At the provider's discretion**, we may request a random drug screen (urine, blood, saliva based on provider discretion).
6. **From time to time**, we may request you bring in your medication.
7. **Depending on treatment, we may refer you** for psychiatric treatment, psychotherapy, psychological treatment or referral to pain management specialist / addictionologist if my provider deems necessary.

Pharmacy: _____

Address: _____ Phone Number: _____

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. Upon request, a copy of this document and the Patient Rights and Responsibilities will be given to me.

Patient/Responsible party signature:_____ Date:_____Time: _____

Minors (13 years and older) Signature:_____ Date:_____Time: _____

Prescriber/provider signature:_____Date:_____Time: _____