



Patient Agreement for Treatment with Controlled Substances*

A Controlled Substance is a drug, medicine or other substance that is tightly controlled by the government because it may be abused or cause addiction. Some examples are: Stimulants (such as Adderall, Concerta, Ritalin&Vyvanse), Opioids (such as Oxycodone, Percocet, Methadone, Vicodin& Fentanyl), Benzodiazepines (such as Valium/Diazepam, Ativan/Lorazepam, Klonopin/Clonazepam & Xanax/Alprazolam), and other drugs such as Ambien and Suboxone.

I, _____, understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments with the doctor/prescriber
- I will participate in all other types of treatment that I am asked to participate in.
- I will keep the medicine safe, secure and out of the reach of others, especially children.
- If the medicine is lost or stolen, I understand it may not be replaced until my next appointment, and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it without first talking to the doctor/prescriber or clinic staff.
- I will not call between appointments, or at night or on the weekends asking for refills.
- I understand that prescriptions may be filled only during scheduled office visits.
- I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell the clinic staff immediately.
- I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.
- I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.
- I will sign a release form to let the doctor/prescriber speak to all other doctors or providers that I see.
- I will tell the doctor/prescriber all other medicines that I take, and let him/her know if I have a prescription for a new medicine.
- I will not get any controlled drug/medicine (see above) without telling the doctor/prescriber or clinic staff before I fill that prescription.
- I will not use illegal drugs such as amphetamines, cocaine or heroin, cocaine. I will let the doctor/prescriber know if I have or get a medical marijuana card.
- I agree to submit to a blood or urine test as asked by the doctor/prescriber.
- I will use only one pharmacy to get all my medicines:
Pharmacy name/phone#: _____
- I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient Name: _____

Patient Signature: _____

Date: _____