PRIMARY CARE
ASSOCIATES OF TEXAS

Controlled Substance Medication Agreement

I, (name) _____ (DOB) _____,
Understand that my physician (hereinafter to refer to "physician") is prescribing a controlled substance medication as part of my treatment plan. This controlled substance agreement ("Agreement") is a tool for communication allowing us to work together in good faith and for you to understand the importance of this medication. In prescribing a controlled substance medication, we must partner with our patients to create the best treatment plan for your improvement and/or management of pain. This requires cooperation, trust and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled pain medication and the failure to continue to follow all terms will result in discontinuing the controlled medication and/or dismissal from our practice.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my physician. Initial _____

2. I will keep regularly scheduled appointments with my physician. There may be times when your medication will need a refill between office visits. If that occurs, please call our staff at least 5 days before your medication runs out. Refill requests will only be taken Monday-Friday from 8am –5pm. Your physician or an on-call physician will not refill pain medications after hours or on weekends. If you have uncontrolled pain during a weekend, medical care should be sought from an emergency room or immediate care center.
   Initial: _____

3. The controlled substance medication prescribed is being given to control pain and/or improve function. If there are any changes to your activity level of physical condition, the treatment may be changed or discontinued. You are responsible for notifying your physician of such changes.
   Initial: _____

4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves. If your condition does not improve, your physician may recommend additional conservative or invasive neurosurgical procedures. If your level of pain still does not allow you to taper and discontinue the controlled substance pain medication, you will be referred to a pain management specialist for management of your pain medications. Initial: _____

5. I agree to act responsibly, including protecting and limiting access to these medications by keeping them in a safe place, and to dispose of any unused medication properly. Initial: _____

6. You are not to accept or seek controlled substance medication from any other physician or health care provider outside of our practice while we are prescribing controlled medication. It is essential that only one physician monitor and evaluate your use of pain medication. Initial: _____

7. If you have another condition that requires the prescription of a controlled substance medication (tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing

8. It is required that you use a single pharmacy for all prescriptions (provide pharmacy information below). You may use a chain of pharmacies with different branches, as the prescription information is available at all branches. This is required to make certain that our medications are known by a pharmacist able to evaluate any concerns about interaction of medications. Initial: _____

9. I understand that lost, stolen or misplace prescriptions or pills will not be replaces. All patients are required to act responsibly with their medications. This medication is prescribed for you and only your specific needs. To allow others to use your medication is illegal and dangerous. This type of behavior will not be tolerated by your physician or our practice. Proof of a police report will need to be provided should a theft occur.

10. I agree that I will not use any other illegal and/or recreational drug while receiving care and pain medication from this practice. Use of illegal and/or recreational drugs, especially while also taking pain medications, is extremely dangerous and potentially lethal. Initial: _____

11. I recognize altering a prescription in any way is against the law. Fabricating prescriptions or forging a provider's signature is also against the laws. I realize if I commit this law violation it will be reported to my pharmacy, local authorities and the Drug Enforcement Agency. Initial: _____

12. I agree and understand that my physician reserves the right to obtain random or unannounced prescription drug testing. The drug testing will be required at a minimum of the onset of the prescription and every 3-6 months thereafter depending upon the medication a dosage. If I fail to provide the sample when asked or if the results are inconsistent, I may forfeit the right to continue receiving care.
    Initial: _____

13. You should inform your physician of all medications you are taking including herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone. Initial _____

14. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory to obtain or provide information about your care or actions, if the physician feels it is necessary. Initial: _____

Pharmacy Name: _____ Phone Number: _____

IF YOU HAVE ANY QUESTIONS CONCERNING OUR MEDICATION AGREEMENT OR WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF.

I have read this agreement. I fully understand the consequences or violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Print Name: _____ DOB: _____

Signature: _____ DATE: _____