Controlled Substances Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medications you may be prescribed. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand that this agreement is essential to the trust and confidence necessary in a doctor patient relationship and that my provider undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my provider will stop prescribing controlled substances.
- In the event that this agreement is violated, my doctor will taper off the medication over a certain period of days, as necessary to avoid withdrawal symptoms. Also, a drug dependence program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my condition, the effect of the symptoms upon my daily life, and how well the medication helps to relieve my symptoms.
- I will not use any illegal controlled substance, including marijuana, cocaine, etc.
- I will not share, sell, or trade my medication with anyone.
- I will not attempt to obtain any controlled substances from any other provider.
- I will safeguard my medication from loss or theft**. Lost or stolen medication will not be replaced.**
- I agree that refills of my prescriptions for controlled substances will be made only at the time of scheduled office visits or during regular office hours. No refills will be available during evenings or weekends.
- If there is a request for any early refills on (3) occasions, controlled substances will be discontinued.
- I understand that consecutive missed appointments may result in the disruption of services.
- I agree that I will submit a blood or urine test if requested by my doctor to determine my compliance with the controlled substances agreement and to determine the use of other controlled substances.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use at a greater rate will result in my being without my medication for a period of time.
- I will bring all unused controlled substances to every office visit.
- 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.

I agree to use_____pharmacy at_____location.

This agreement has been entered into on this_____day of_____.

Printed Patient Name_____DOB____/____/_____

Patient Signature_____