

 Controlled Substance Agreement

Effective date 9/1/2024

The purpose of this controlled substance agreement is to establish an agreement between the medical provider and patient regarding how controlled substances will be prescribed, and safely and effectively used. This agreement is essential to the trust and confidence necessary in a physician/patient relationship. Controlled substances include pain medications, anti-anxiety medications, sleep aids, or medications used to treat Attention Deficit Disorder or narcolepsy.

I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life,and how well this medicine is helping to relieve the pain. I understand that all controlled substances carry a risk of side effects, dependence or tolerance. I agree to use the minimum effective dose and accept responsibility for all side effects of medications.

I understand that regular follow-up visits to evaluate my medical condition and treatment plan are required**. I agree that refills of my prescriptions for controlled substances will be made only at the time of an office visit. I understand that if I miss my regular follow up appointments, refills may be denied until I am seen and evaluated.** No refills will be available during evenings or weekends. Early refills will generally not be given.

I will bring all unused medication in their original containers to office visits, if requested. I understand I may need to submit to random pill counts of my medications.

I understand that my medical provider will regularly check the North Carolina Controlled Substance Reporting Systemto verify my prescription history and to take necessary action related to any information found on this site.

**NOTE:** The providers use the Unintentional OVERDOSE Risk Score located on this website to evaluate use of controlled medications. **If this score is ABOVE AVERAGE, then we will need to decrease the medications.** The provider will work with you to safely decrease your medication. You will need to be AVERAGE and not at risk for us to continue your medications.

I will not share, sell or trade medications with anyone. I understand that sharing medications with other people is a violation of federal laws for which I can be prosecuted.

I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the North Carolina Board of Pharmacy,in the investigation of any possible misuse, sale, or other diversion of my controlled substance prescriptions.

I authorize Family Care of Black Mountain/Old Fort 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 will **only** obtain controlled substance medication from providers at Family Care of Black Mountain and Old Fort. I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants or anti-anxiety medicines from any other medical office, dentist, or emergency room. (An exception to this is if you are being followed by pain management or psychologist and prescribed controlled medications.) Rare exceptions may be made if discussed with the provider first.

I will safeguard my prescriptions from loss or theft. I understand that lost or stolen medications will not be replaced. (If your medication has been stolen, and you complete a police report regarding the theft, an exception may be made, but is not guaranteed.)

Since my medication may be hazardous or deadly to children or others who are not tolerant to their effects, I will keep all medication in a safe place away from any children, adolescents, or adults who may live in or visit my home.

I agree to only use one pharmacy for controlled substance refills.

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I agree that I will submit to a blood, oral or urine test if requested, to determine my compliance with my medication plan. I understand that regular drug screens are a part of my controlled substance agreement and/or pain management plan.

I understand that random drug screens will be performed throughout the year.

I also agree:

(1) If any illegal substances or controlled medications not prescribed by this office are found in these screens, this contract for controlled substance prescriptions will be terminated, and further action, including dismissal from the practice may occur.

(2) If I am going to pain management or psychologist and this has already been disclosed to the office, that medication is expected to be seen on a drug screen.

(3) If the controlled medication that is prescribed for me is not found on these screens, refills will be up to the provider’s discretion.

I agree that I will use my medication at a rate no greater than the prescribed rate, and that each prescription is designated to last a specific timeframe;typically, 28 to 30 days. **I understand that if I take more medication than prescribed, this will result in me being out of my medication and I assume all risks and side effects** **as a consequence.**

I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped, and I may be dismissed from the practice.

I understand that if I break this Agreement, my provider will stop prescribing controlled substance medications for me. In this case, I will be tapered off the medicine over a period that the provider deems safe to avoid withdrawal symptoms.Also, a drug dependence treatment program may be recommended.

I fully accept and agree to the terms and conditions set forth in this document. All my questions and concerns about treatment have been adequately answered. A copy of this document has been given to me.

Patient Name (printed) Date of birth

**Patient Signature** Date

**If Patient is a minor:**

**Parent/Guar Signature** Date Medical Provider Date