Controlled Substance Agreement

The purpose of this agreement is to outline the conditions under which my provider at Golden Victory Medical will prescribe controlled substances. By signing this form, I acknowledge I have been informed that individuals who are prescribed certain controlled substances including, but not limited to, narcotic pain medicines, stimulants, benzodiazepines, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this contract for my provider to consider prescribing or to continue prescribing controlled substances to treat my condition.

- I agree to abide by the terms of this agreement. I understand that upon my first violation of this agreement, my provider will not prescribe my controlled substance until the next original due date and that after the second violation my provider will stop prescribing me all controlled substances. They also have the right to discharge me from the practice and refer me elsewhere.
- I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family. ·All controlled substances used to treat my mental health condition must come from my provider at Golden Victory Medical, my pain management specialist, or during their absence, by the covering provider, unless specific written authorization is obtained from the office for an exception. Exceptions may be made for emergency acute care. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform the provider and the pharmacy of the change.
- I will inform my provider of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
- I will inform my other health care providers of the medications I am prescribed and of the existence of this agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers. I will not allow anyone else to share, have, use, sell, or otherwise have access to these medications. The sharing of medications with anyone is forbidden and is against the law. I will store my medication in a secure location to prevent it from being lost, stolen, or unintentionally used by others.
- I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety. I understand that tampering with a written prescription is a felony, and I will not change or tamper with my doctor's written prescription. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

- I agree not to alter my medication in any way, and I will take my medication whole. It will not be broken, chewed, crushed, injected, or snorted.
- I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by my provider.
- I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
- I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication. Failure to comply may result in immediate discharge from the practice.
- I understand that the presence of unauthorized and/or illegal substances in the toxicology screenings may prompt referral for assessment for a substance use disorder or discharge from the practice.
- I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report will be required before additional prescriptions are considered. There is no guarantee my provider will prescribe my medication early. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, I may be discharged from the practice. I understand if legal authorities have questions concerning my treatment due to concern for any sale, misuse, or diversion that my provider will cooperate fully with any law enforcement agency and these authorities may be given full access to my records of controlled substance administration.
- I will not use any illegal substances (e.g., marijuana, cocaine, etc.) and I will not misuse or self-prescribe/ medicate with legal controlled substances.

I understand that my provider will use the resources available to verify my compliance with this agreement including, but not limited to, my pharmacy and the Prescription Drug Monitoring program. I understand that failure to adhere to these policies and/or failure to comply with the provider's treatment plan may result in cessation of therapy with the controlled substance prescribed by this provider and/or a referral for further specialty assessment, as well as discharge from the practice. I, the undersigned patient, attest that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

Date: _____

Patient's Printed Name: _____

Patient's Signature: _____