

Controlled Substance Agreement

Patient Name: _____ DOB: _____

To ensure the safe and responsible use of controlled substances (e.g., opioids, benzodiazepines, stimulants), Pandora Family Medicine requires all patients receiving these medications to agree to the following terms:

Please initial each item and sign at the end.

1. Purpose

___ Controlled substances may be prescribed to manage certain medical conditions. These medications carry the risk of dependence, misuse, and diversion, and therefore require close monitoring.

2. Single Provider and Pharmacy

___ I agree to receive all controlled substance prescriptions solely from this office.

___ I will use one pharmacy for all my controlled medications. Pharmacy: _____

3. Medication Use

___ I will take the medication exactly as prescribed.

___ I will not change the dose or schedule without provider approval.

___ I understand that refills of controlled substances will require an appointment, no exceptions.

___ I understand that lost, stolen, or destroyed prescriptions will not be replaced early, without a police report.

4. Monitoring and Follow-up

___ I will attend all scheduled appointments. Telemedicine visits are acceptable for refills.

___ I agree to participate in random urine or blood drug screenings if requested. Refills will not be provided outside of scheduled office visits or after-hours.

5. Prohibited Behavior

___ I will not share, sell, or misuse my medications.

___ I will not obtain controlled substances from other providers without notifying Pandora Family Medicine.

___ I acknowledge that misuse, diversion, or noncompliance may result in termination of treatment with controlled substances or dismissal from the practice.

6. Medication Discontinuation

___ I understand that the medication may be reduced or stopped if it is no longer effective, medically necessary, or used appropriately.

Patient Signature: _____ Date: _____