Controlled Medication Contract

Patient Name: _____ **DOB:** _____

The purpose of this contract is to define the expectations between Incredible Family Health & Wellness and the patient regarding the use of all controlled medications.

I understand that controlled medications carry the risk of addiction as well as side effects from the medication. I understand these medications may impair my ability to operate a motor vehicle or heavy equipment. It may also impair my ability to make appropriate decisions. In order to reduce the chances of abuse of the medications, certain parameters regarding the prescription are agreed to:

- I will not use the medicines at higher doses than prescribed.
- I will not ask for or receive any controlled medication prescriptions from other medical providers, except as authorized by my provider.
- I will not ask for early prescription refills except under emergency conditions i.e. weather related.
- No replacements will be provided for lost/stolen medications or prescriptions.
- If an early refill is granted for reasons of travel, weather, etc.The next refill will be delayed by an amount of time equal to the number of days early the refill is given.
- I understand that Incredible Family Health & Wellness will refer me to a pain specialist for chronic pain management. Chronic Narcotic pain management is not part of the services provided by Incredible Family Health & Wellness.
- I understand that the provider will need to see me on regularly scheduled visits for controlled prescriptions. I understand that it is my responsibility to schedule these appointments.
- I understand that no refills will be made at night, on weekends or holidays. I understand that all refill requests will require at least a 3 day notice and will likely require a visit.
- I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy for all controlled medications. I will notify the provider if I change pharmacies.
- I understand that the provider requires random drug testing and maybe required before any fill/refill is authorized.
- I understand that state and federal laws/guidelines will be followed and maintained for all individuals using controlled medications.

I have been informed that I may not take other drugs such as tranquilizers, pain medications, sedatives or antihistamines without first consulting with my provider. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression/distress, and in worse cases death. Failure to abide by these parameters will be grounds for termination of any and all controlled prescriptions from Incredible Family Health & Wellness.

I have read and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist if needed.

Patient Signature: _____ Date: _____

Provider Signature: _____Date: _____