North Texas Family Health

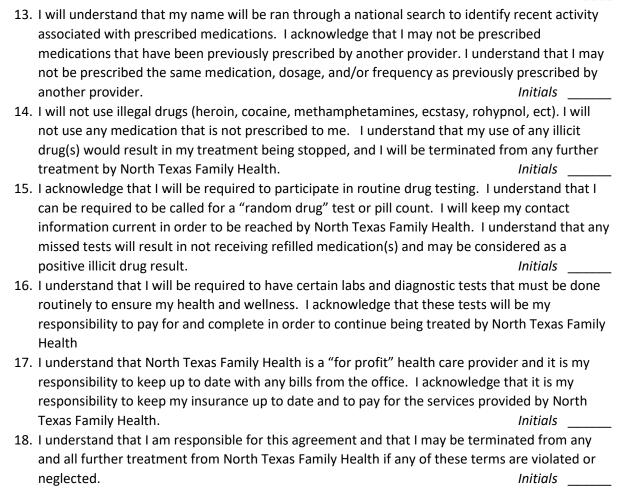
2019

Treatment with Controlled Medications Patient Agreement Form

l,	(<i>Print Name</i>), understand and voluntarily agree that:		
	(initial each statement below after reviewing)		
1.	I will keep and be on time for all my scheduled appointments with the provide	r(s) of North Texas	
	Family Health.	Initials	
2.	I will participate in all treatments that I am required to participate in while bein	ng treated by the	
	provider(s) of North Texas Family Health.	Initials	
3.	I will keep my prescribed medication(s) safe, secure, and out of reach of children	en. If my	
	medicine is lost or stolen, I understand that it will not be replaced until my nex	t scheduled	
	appointment at North Texas Family Health and may not be replaced at all.	Initials	
4.	I will take my medication as instructed and not change the way I take it without	t first talking to	
	the provider(s) of my treatment team at North Texas Family Health.	Initials	
5.	I will not call between appointments, or at night, weekends, off hours, etc., ask	_	
	understand that prescriptions will be filled only during scheduled office visits b		
	of North Texas Family Health.	Initials	
6.	I will make sure that I have established an appointment for refills. If I am havir	-	
	making an appointment, I will contact a provider at North Texas Family Health		
	business days before my next expected refill appointment.	Initials	
7.	I will treat all staff at North Texas Family Health with respect. I understand that		
	disrespectful to the staff or disrupt the care of other patients at North Texas Fa		
	treatment will be stopped, and I will be terminated from further treatment fro		
_		Initials	
8.	I will not sell or share this medication to others. I understand that if I do, my tr		
	stopped, and I will be terminated from further treatment at North Texas Famil		
^	Lucillation and accompany allowing all annuithous whom I am to attend by the disco-	Initials	
9.	I will sign a release form, allowing all providers, whom I am treated by, to discu		
10	and treatment expectations.	Initials	
10.	. I will tell the provider(s) at North Texas Family Health, all of the medications the		
	will notify the provider(s) when I get a new prescription from another provider (including Dentists, Urgent Care, Emergency Departments, and specialists).	Initials	
11	. I limit my prescriptions to no more than two pharmacies to be filled. I underst		
11.	responsibility to comply with the pharmacy(s) policies and procedures and that		
	Family Health is not responsible for the pharmacy(s) policies. The name of the		
	pharmacy(s) that I will use are listed below.	Initials	
12	. I will not get any opioid pain medication (includes Tylenol with codeine) or oth		
12	medications such as benzodiazepines (Ativan, Klonopin, Valium, Xanax, etc) or		
	(Adderall, Ritalin, Vyvanse, etc) without first notifying a provider(s) at North Te		
	Health, before filling that prescription. I understand that the only expectation		
	hy an emergency department at night on weekends or after hours	_	

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Controlled Medication Treatment Statement

North Texas Family Health is making a commitment to facilitate your health care by providing the following commitments:

- We will assist you in scheduling routine appointments to evaluate the effectiveness, compliance, safety, and necessity of your treatment.
- If we need to change or cancel your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will ensure that your treatment is as safe as possible. We will routinely evaluate the effectiveness, compliance, safety, and necessity of your treatment and make alterations that best facilitate to your complete wellness.
- We will evaluate your prescriptions and drug tests regularly to evaluate treatment effectiveness, compliance, safety, and necessity.
- We will work cooperatively with other providers, specialties, and services to provide a consistent, safe, and effective care plan.
- We will set treatment goals and monitor your progress in achieving those goals.
- We will work with your insurance provider(s) and specialized assistance programs to facilitate that you are able to initialize or continue treatment.

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• We will monitor and provide alternative treatments to minimize the potential of developing an addiction to the medications being prescribed.

Patient Information	on:		
First Name:	Middle initial:	Last Name:	
Preferred Name to be called	at North Texas Family Health	h:	
Best mode of contact: (pleas preferred mode of contact a		t below and check the space that is your	
phone # (
email			
text message # (
mailing address			
other			
Pharmacy Information: Preferred Pharmacy: Secondary Pharmacy	Address:	extext	
Patient Signature:			
Today's Date:			
Provider's Signature:	X/m F	Date:	

*Adapted from the American Academy of Pain Medicine http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203