North Texas Family Health

2019

Treatment with Controlled Medications
Patient Agreement Form

I, _____ (*Print Name*), 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 provider(s) of North Texas Family Health. *Initials* _____
2. I will participate in all treatments that I am required to participate in while being 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. If my medicine is lost or stolen, I understand that it will not be replaced until my next 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 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., asking for refills. I understand that prescriptions will be filled only during scheduled office visits by the provider(s) of North Texas Family Health. *Initials* _____
6. I will make sure that I have established an appointment for refills. If I am having difficulty making an appointment, I will contact a provider at North Texas Family Health no earlier than 5 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 if I am disrespectful to the staff or disrupt the care of other patients at North Texas Family Health, my treatment will be stopped, and I will be terminated from further treatment from this clinic. *Initials* _____
8. I will not sell or share this medication to others. I understand that if I do, my treatment will be stopped, and I will be terminated from further treatment at North Texas Family Health. *Initials* _____
9. I will sign a release form, allowing all providers, whom I am treated by, to discuss my care plan and treatment expectations. *Initials* _____
10. I will tell the provider(s) at North Texas Family Health, all of the medications that I take, and I will notify the provider(s) when I get a new prescription from another provider or service (including Dentists, Urgent Care, Emergency Departments, and specialists). *Initials* _____
11. I limit my prescriptions to no more than two pharmacies to be filled. I understand that it is my responsibility to comply with the pharmacy(s) policies and procedures and that North Texas Family Health is not responsible for the pharmacy(s) policies. The name of the (two) pharmacy(s) that I will use are listed below. *Initials* _____
12. I will not get any opioid pain medication (includes Tylenol with codeine) or other “addictive” medications such as benzodiazepines (Ativan, Klonopin, Valium, Xanax, etc) or stimulants (Adderall, Ritalin, Vyvanse, etc) without first notifying a provider(s) at North Texas Family Health, before filling that prescription. I understand that the only expectation would be if given by an emergency department at night, on weekends, or after hours. *Initials* _____

13. I will understand that my name will be ran through a national search to identify recent activity associated with prescribed medications. I acknowledge that I may not be prescribed medications that have been previously prescribed by another provider. I understand that I may not be prescribed the same medication, dosage, and/or frequency as previously prescribed by another provider. *Initials* _____
14. I will not use illegal drugs (heroin, cocaine, methamphetamines, ecstasy, rohypnol, ect). I will not use any medication that is not prescribed to me. I understand that my use of any illicit drug(s) would result in my treatment being stopped, and I will be terminated from any further treatment by North Texas Family Health. *Initials* _____
15. I acknowledge that I will be required to participate in routine drug testing. I understand that I can be required to be called for a "random drug" test or pill count. I will keep my contact information current in order to be reached by North Texas Family Health. I understand that any missed tests will result in not receiving refilled medication(s) and may be considered as a positive illicit drug result. *Initials* _____
16. I understand that I will be required to have certain labs and diagnostic tests that must be done routinely to ensure my health and wellness. I acknowledge that these tests will be my responsibility to pay for and complete in order to continue being treated by North Texas Family Health
17. I understand that North Texas Family Health is a "for profit" health care provider and it is my responsibility to keep up to date with any bills from the office. I acknowledge that it is my responsibility to keep my insurance up to date and to pay for the services provided by North Texas Family Health. *Initials* _____
18. I understand that I am responsible for this agreement and that I may be terminated from any and all further treatment from North Texas Family Health if any of these terms are violated or neglected. *Initials* _____

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:

First Name: _____ Middle initial: _____ Last Name: _____

Preferred Name to be called at North Texas Family Health: _____

Best mode of contact: (please fill out all modes of contact below and check the space that is your preferred mode of contact and communication)

___ phone # (_____) _____ - _____

___ email _____

___ text message # (_____) _____ - _____

___ mailing address _____

___ other _____

Pharmacy Information:

Preferred Pharmacy: Name: _____

Address: _____

Phone Number: (_____) _____ - _____ ext. _____

Secondary Pharmacy: Name: _____

Address: _____

Phone Number: (_____) _____ - _____ ext. _____

Patient Signature: _____

Today's Date: _____

Provider's Signature: _____ FNP-BC Date: _____

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