BEYOND FAMILY MEDICINE, LLC

CONTROLLED SUBSTANCE AGREEMENT

Controlled substance medications (ie: narcotics, benzodiazepines, tranquilizers, stimulants, etc) can be useful in medical practice, but have high potential for misuse, dependence, and adverse effects. These drugs are closely monitored by local, state, and federal governments. They are intended as treatment for reasons including, but not limited to, pain, anxiety, insomnia, attention deficit, etc. Dr. Freyman has agreed to work together with me (and any necessary specialists) in the management of my controlled medication(s) to help manage my medical condition(s) and I therefore agree to the following:

1) I am responsible for maintaining all medications prescribed to me. If my prescription is misplaced or stolen, I understand it will NOT be replaced regardless of circumstance.

2) I will take my medication as directed by my physician and understand that refills will NOT be given early at any time. Medication adjustments and refill requests will be handled only during regular office hours, in person, and at the discretion of my treating physician.

3) I understand I may be required by my physician to consult periodically with a specialist regarding the management of my controlled substance medication. If I do not comply with this request, I acknowledge my medication may be discontinued, or may not be refilled beyond tapering dose to completion.

4) I agree to comply with random drug testing or pill counts at any appointment, if needed.

5) I have been counseled appropriately and fully understand the risks, benefits, and alternatives to taking controlled substance medications. I agree to work together with my physician(s) to reach my health goals by following the prescribed treatment plan. I will strive to maintain better health habits with diet and exercise, avoid tobacco and alcohol, and/or improve stress and coping skills with counseling as needed which is readily available through EAP.

6) It is my responsibility to be aware of the potential adverse effects of taking controlled substance medication, including but not limited to, permanent disability and death.

7) I understand that I violate this agreement due to non-compliance I will no longer be able to receive my controlled substance medications at this clinic. It will be my responsibility to secure follow-up with an outside physician for follow-up evaluation and treatment.

I have read and agree to the above.

Patient Signature: ________________________________ Date: __________

Physician Signature: ______________________________ Date: __________