ARCHANGEL MICHAEL HEALTH, PA

Controlled Substance Agreement

Last Updated: May 15, 2025

PATIENT NAME:

DATE OF BIRTH:

PARENT/GUARDIAN NAME(S) (if applicable):

The purpose of this Agreement is to enter a mutual agreement regarding certain medications (controlled substances such as opioids, benzodiazepines, hypnotics, stimulants, and other controlled medications) you will be taking or could be taking in the future. Prescriptions of controlled substances are strictly monitored by state and federal law, so strict accountability is necessary.

Patient Responsibility

1. I understand that this Agreement is based on the trust and confidence necessary in a provider/patient relationship and that Dr. Bray will manage controlled substances based on this agreement.

2. I understand that if this agreement is broken, no further prescriptions will be written.

3. I agree to notify Dr. Bray of any and all controlled substances or prescriptions that I receive from other providers. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or benzodiazepine/hypnotic medications from any other provider unless that provider is co-managing care with Dr. Bray.

4. I agree to follow Dr. Bray's recommendation to seek psychiatric treatment, psychotherapy, psychological treatment, or referral to a pain management specialist or addiction specialist if deemed necessary.

5. I understand that someday Dr. Bray may recommend weaning me partially or totally from controlled substances and that other treatment options may be suggested. Abruptly stopping certain medications can cause serious risk to my health, and any weaning instructions must be followed explicitly.

6. I understand that controlled substances have potential risks and side effects, including the risk of addiction. An overdose with a controlled substance may cause injury or death. I also understand that controlled substances may impair my ability to drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy and subject me to regulations concerning driving while under the influence of drugs, for which I am responsible in adhering to those regulations.

   (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking these medications, I will immediately inform my obstetric provider and Dr. Bray.

7. I understand that controlled substances can interact with other medications. I will not use any recreational mind-altering or illicit substances (i.e., marijuana, cocaine, methamphetamine, etc.). I will inform Dr. Bray of ALL current medications including herbs, vitamins, supplements, and over-the-counter medications. I understand the combination of opioids, benzodiazepines/hypnotics, or other controlled substances with CNS depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death.

8. I will not alter my medicine in any way or use any other administrative method other than what has been prescribed. I will take my medication whole; my medication will not be broken, chewed, crushed, injected, or snorted.

9. I agree that I will use my medicine as prescribed and that use of my medicine at a greater rate will result in my being without medication for a period of time and possible termination of care. I will avoid withdrawal symptoms by taking medication as directed, not taking more medications than

prescribed, and keeping my appointments for refills. I understand that 'running out' of medication is not grounds for insisting on an 'emergency or urgent appointment'.

10. Any change in dosage must be approved by Dr. Bray at Archangel Michael Health. **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law. Forged prescriptions and/or forged provider's signatures are also against the law.** If any of these instances occur, it will result in an immediate termination from this practice and report to local authorities.

11. I agree that refills of my prescriptions for controlled substances will be made only at the time of an office visit or during regular office hours and not earlier than the agreed renewal date. No refills will be available during evenings or on weekends or by phone.

12. I will safeguard my controlled substances from loss or theft and will not share, sell, or trade my medication with anyone, nor will I take other individual's prescribed controlled substances. I understand that if I am suspected of diverting or distributing my controlled substances, Dr. Bray will immediately cease prescribing these medications, and this will likely be cause for dismissal from the practice. In this case, Dr. Bray will be required to comply with local, state, and/or federal reporting requirements and investigation. Lost or stolen medicines will not be replaced.

13. I authorize Archangel Michael Health, if directed by law enforcement agencies, to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled substances. If requested, I authorize Dr. Bray to provide a copy of this agreement to my pharmacy or to the requesting government agency. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

14. I agree that I will submit to a blood or urine test if requested by Dr. Bray to determine my compliance with my program of controlled substance. Tests may include screens for illegal substances, and my cooperation is required. Refusal of such testing may subject me to an abrupt/rapid wean schedule in order for the medication to be discontinued or prompt termination from this practice.

15. I will bring all unused controlled substances when requested by Dr. Bray.

16. I agree to abide by Archangel Michael Health's Patient Rights and Responsibilities and understand that any serious misbehavior such as yelling, threatening, cursing, etc. will likely be cause for dismissal from the practice.

Provider/Practice Responsibility

1. We will provide the best evidence-based care for your condition.
2. We will help set functional goals with you (which may include pain control goals if applicable).
3. We will assess and discuss with you the risk/benefit/safety of your medications.
4. Before writing any controlled substance prescriptions, we will check the state prescription monitoring database.
5. At Dr. Bray's discretion, we may request a random drug screen (urine, blood, saliva based on provider discretion).
6. From time to time, we may request you bring in your medication.
7. Depending on treatment, we may refer you for psychiatric treatment, psychotherapy, psychological treatment, or referral to a pain management specialist or addiction specialist if deemed necessary.

Pharmacy:

Address:

Phone Number:

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. Upon request, a copy of this document and the Patient Rights and Responsibilities will be given to me.

Patient/Responsible Party Signature:

_____

Date: _____

Time: _____

Minors (13 years and older) Signature:

_____

Date: _____

Time: _____

Prescriber/Provider Signature:

_____

Date: _____

Time: _____

Archangel Michael Health, PA

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