Controlled Substances / Pain Management Agreement

I _____ understand that I am being prescribed a controlled substance medication by my provider for _____.

To avoid potential complications due to my prescribed medication regimen, I am willing to comply with the following guidelines:

(Patient to initial each section below)

1. _____ I will take only those controlled medications and in the doses prescribed by my provider.

2. _____ I will not increase, stop, or alter my dose of controlled substance medication without prior approval of my provider. I understand that increasing my dose without authorization or obtaining controlled prescriptions outside of David Powell Clinic may result in the discontinuation of all controlled substances.

3. _____ I will inform other providers and dentists involved in my care which controlled medications I am taking

4. _____ I will submit to drug testing on a random basis as requested by David Powell Clinic providers including doctors, nurse practitioners, social workers, and nutritionists. If drugs which have not been prescribed are found in my blood or urine, or excessive levels of prescribed drugs are found, or if prescribed drugs are not found, all controlled substance medication prescriptions may be discontinued at the discretion of my primary care provider. ***All decisions will be made based on optimizing or improving my health.***

5. _____ I understand I must keep my follow-up appointments as directed by my provider or as follows: _____

6. _____ I will not obtain any narcotics or other controlled substance prescriptions from other any other healthcare providers including doctors or dentists. I will obtain controlled substance medications only from my provider or in certain instances from other David Powell Clinic providers.

7. _____ I agree to actively participate in diagnostic testing, physical therapy, counseling, and undergo psychological and/or psychiatric evaluations or any other forms of treatment as recommended by providers.

8. _____ I will not ask for controlled substance prescriptions from any David Powell Clinic healthcare providers until my scheduled appointment unless I am going to run out of my controlled substance medication taken at the prescribed dosage prior to a scheduled appointment.

9. _____ I will fill all controlled substance prescriptions at one pharmacy.

   Pharmacy: _____ Telephone: _____

10. _____ I authorize my David Powell Clinic provider or his/her designee to call any pharmacy or other healthcare provider treating me, to verify compliance with these guidelines.

11. _____ I understand the side effects of these medications may include dizziness, sleepiness, and altered consciousness. I understand that my ability to operate heavy machinery and/or drive may be affected and by doing so I may cause possible fatal injury to myself or others while taking this medication. I might be arrested for and/or charged with driving under the influence (DUI) of a substance. I will not perform potentially hazardous tasks while taking this medication.

12. _____ I understand that lost or stolen medications may not be replaced and that a police report may be required to resume medications in certain instances.

13. _____ I understand my provider may stop prescribing controlled substance medications if it is felt there is not continued need, or if the risks of this medication are greater than the possible benefits.

14. _____ I understand that addiction and/or physical dependence to controlled substances may develop with correct or incorrect use of these medications. I will receive the appropriate treatment and/or referrals for these problems if they develop.

My signature below indicates that I understand the above guidelines and that the controlled substances may be stopped for medical reasons. I understand that a violation of any of the above may be cause for discontinuation of my controlled substance medications.

Signatures:

Patient _____ Date _____

Provider _____ Date _____

Witness _____ Date _____