Superior Health and Wellness
"Personalized care for you"

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# CONTROLLED SUBSTANCES AGREEMENT FORM

The purpose of this agreement is to prevent any misunderstandings regarding controlled substances that you may be prescribed by the providers at this clinic. The goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. This agreement is also set forth to assist you and your provider to comply with the law regarding controlled pharmaceuticals.

Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following polices are agreed to by you, the patient, to help maintain safety and provide quality, effective care.

I agree to the following:

- I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's medication.
- I will not increase my medication until I speak with my provider. If I do so on my own, the provider may taper and d/c medication. Use of medication at a greater rate than prescribed may result in my being without medication for a period of time.
- My medication may not be replaced if it is lost, stolen or consumed earlier than prescribed. My prescription for a controlled substance may not be replaced if lost/stolen.
- Renewals are contingent on keeping scheduled appointments. I will not phone/text for prescriptions after hours or on weekends. Early refills will not be given.
- I agree to voluntary urine drug testing for controlled substances before initiation of therapy and that random urine follow-up testing may be done even if not covered by my insurance. If there is a presence of unauthorized substances, illicit substances or absence of prescribed medications, I may be referred for assessment for addictive disorder and possibly tapered and discontinued from the controlled substance immediately or in the future.
- I will exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery.
- I will not obtain any controlled medications, including benzodiazepines, controlled stimulants or anti-anxiety medications to treat the same symptoms from any other doctor.

You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ Address: _____

I understand that if I break this Agreement, my provider may stop prescribing me certain medications and /or release me from the practice. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding this agreement have been adequately answered.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness Name: _____ Witness Signature: _____