Treatment with Controlled Medications: Patient Agreement

I _____ understand and voluntarily agree: (initial each statement after reviewing):

____I will keep (and be on time for) all my scheduled appointments with the doctor.

____I will participate in all other types of treatment that I am asked to participate in.

____I will keep the medicine safe, secure and out of the reach of children and other adults. If the medicine is lost or stolen, I understand it may not be replaced until my next refill date, and may not be replaced at all.

____I will take my medication as instructed and will not change the way I take it without first talking to the doctor.

____I will not request early refills. I understand that prescriptions will be filled only at the time it is allowed to be filled, and I will pick them up at the pharmacy on that day.

____I will call at least 24 hours prior to the time the medicine is to be refilled.

____I will make sure I have an appointment every three (3) months. If I am having trouble making that appointment, I will tell the doctor immediately.

____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

____I will tell the doctor all other medicines that I take, and let her know right away if I have a prescription for a new medicine.

____I will use only one pharmacy to get all my controlled medicines:

_____

Pharmacy name and phone number

____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium), muscle relaxers (Soma), sleeping meds (Ambien) or stimulants (ritalin, amphetamine) from any other provider without telling the doctor before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency.

____I understand that as always, I have access to this office via phone, email and text 24 hours per day. I further acknowledge that there is no excuse for delaying any notification.

____I will not use illegal drugs such as heroin, cocaine or amphetamines, and I will not take a controlled medicine that has not been prescribed to me. I understand that if I do, my treatment may be stopped.

____I will agree to urine drug testing and/or counting of my pills within 48 hours of being notified. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for unauthorized substances.

____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Treatment Program Statement

We at **Avalon Primary Care, PC**, are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off the medications that are causing you problems safely, without getting sick.

Thank you for your cooperation!

_____	_____	_____
Patient Name	Patient Signature	Date

Louise R. Butler, DO_____	_____	_____
Physician Name	Physician Signature	Date