PRIMECARE MEDICAL GROUP

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. narcotics, stimulants, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my condition(s), I agree to the following conditions:

1. **I am responsible for the controlled substance medications prescribed to me.** If my prescription is lost, misplaced or stolen or if I "run out early," **I understand that it will not be replaced**.
2. **Refills** of controlled substance medications:
   a. **Will be made only during regular office hours** Monday through Friday, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends, or during holidays. **No refills by phone.**
   b. **Will not be made** if I "run out early," or "lose a prescription," or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   c. **Will not be made** as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least twenty-four (24) hours ahead if I need assistance with a refill. **Must be refilled in person in office.**
3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be refilled.
4. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.
5. I understand that **if I violate any of the above conditions,** my prescription for controlled substance medications may be terminated **immediately**. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of nonprescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.
6. I understand that the **main treatment goal is to reduce pain and improve any ability to function and/or work.** In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
7. I understand that the **long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined** and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.

8. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

   Name: _____Phone: _____

Drug Screening Schedule:

- Initial visit – urine drug screen.
- Annual urine drug screen after initial visit.
- A UDT can be repeated at any time per provider discretion.

I have been fully informed by Dr. _____ and his/her staff regarding psychological dependence (addiction) of controlled substance medications, which I understand, is rare. I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect and there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I must do so slowly while under medical supervision or I may have withdrawal symptoms.

I have read this contract and the same has been explained to me by Dr. _____.
In addition, I fully understand the consequences of violating this agreement.

Date _____ Patient Signature _____

Witness Signature _____