OPIOID MANAGEMENT GROUP

Controlled Substance Treatment Agreement

The purpose of this agreement is to set out the rules that this office follows in order to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). The following rules apply to ***all patients*** who receive controlled medications from this office on an ongoing basis. These rules are meant to assure that such medications are prescribed in a ***safe and responsible*** manner.

****Please initial each line to indicate you have read and understood each rule.****

_____1. I will take my medications only as prescribed. I cannot increase the dose without permission from my prescriber.

_____2. I have received a copy of the Opioid Management Pain Contingency Plan and will abide by its outline regarding controlled substances from any other source, including dentists & emergency rooms.
Other controlled medications include:

- Opioid painkillers
- Anti-anxiety medications (such as xanax, klonopin, valium)
- Stimulants (such as ADHD medications or appetite suppressants)

______3. I cannot "try", "borrow", or "use" medications from a relative, friend, or other source.

______4. I cannot take old or "left over" pills, whether prescribed by this office or a previous office.

______5. I cannot sell, trade, or share my medication with anyone, including spouses or other family members

______6. I cannot take more medications than prescribed without permission from this office.
For example, if I am prescribed pain medications three times a day, I may not increase this dose by myself.
Please see our Pain Contingency Plan.

______7. I will avoid **anything** with poppy seeds as it can interfere with drug screens.
This includes poppy seed muffins, poppy seed bagels, or poppy seed salad dressing, or anything else with black seeds such as "everything" bagels.

______8. I understand that controlled medications have street value and **MUST** be safeguarded from theft or loss

- I am responsible for any medications prescribed to me.
- I understand that lost or stolen medication will **NOT** be replaced.

______9. I agree to submit to any requests for urine, saliva and/or blood screens, including random testing.
I am to arrive at my appointments ready to provide a urine sample. If I need to empty my bladder before being seen, I am to ask the staff if I will need to provide urine for a drug screen. **My appointment will be delayed if I am unable to leave a sample when requested. Results MUST be given to the provider before I am seen.**

_____10. If requested, I agree to come in with my prescription medications for a pill count within 24 hours. As a courtesy, we may permit a Virtual Pill Count where you do not have to show up in person but text us a photo of your pills.

_____11. I understand that controlled medications will not be refilled by phone but I must pick up my prescriptions in person.

_____12. I will store my pills only in their original containers to prevent contamination.

_____13. Therapy with pain medications may be discontinued or reduced if my physician feels the risks of ongoing pain medications exceed likely benefits. Reasons for reducing or discontinuing pain medications include but not limited to possible abuse/diversion, worsening lung or mental function.

These rules are non-judgmental; failure to follow the rules might not mean you are abusing medications, but it might mean that we may not be able to prescribe any more controlled medications, even if the infraction was innocent.

I hereby acknowledge I have read, understood the rules above, have had a chance to get answers for any questions, and agree to abide by them.

Patient's Printed Name:____ D.O.B. ____/____/________

Patient's Signature: ____ Date: _____/____/________