Indiana Health GROUP

CONTROLLED SUBSTANCE AGREEMENT

PATIENT NAME: _____ D.O.B._____ Chart #: _____

Please initial next to the following statements to show you have read and understand the statements.

____ Dr. _____, and/or the staff of Indiana Health Group (IHG) have explained the potential risks and benefits of the controlled substance medications that have been prescribed for me.

____ My medications are to be taken ONLY as prescribed. I must discuss any medication changes during an office visit with my doctor prior to making any medication changes. I understand that if I change dosages without supervision, I could overdose, withdrawal, or potentially experience fatal consequences.

____ I will notify IHG immediately if I have any type of side effects from my medications.

____ I will make my provider aware of all medications I am taking, especially any other controlled substances as well as the names of the health care providers prescribing these other medications.

____ I will avoid drinking alcohol and the use of illicit/illegal drugs while taking controlled substances. I understand the risks of combining alcohol and/or illegal substances with these medications.

____ I understand that there is a risk of addiction to controlled substances.

____ I will NOT share or sell my controlled substances as I understand this is against the law.

____ I understand that random urine and/or saliva screens may be requested at any time and are a routine part of office procedure for all people taking controlled substances. I understand that if I fail to take a drug screen, I am in violation of this agreement. I understand if my drug screen is negative for the medications prescribed, I will be in violation of this agreement.

____ I understand I may be asked to bring in my controlled substance prescription bottles at any time for a pill count. If I fail to bring my bottles in that this is a violation of this agreement.

____ I will safely store my medications so that my medications are not stolen or lost. I will store my medications out of the reach of children or other family members. **I understand that my medications will NOT be replaced if lost, stolen, fall into the toilet, are eaten by pets, left on an airplane, or any other reason.**

____ I understand that there are **NO early refills**. If I run out my medications early due to overusing them, I may be at risk for withdrawal symptoms that could put my life in danger. I understand that I may have to be hospitalized to prevent life-threatening withdrawal symptoms.

____ I understand that refills of controlled substances will ONLY be given if I keep my scheduled appointment.

PATIENT NAME: _____

____ I understand that I, *not my pharmacy*, must call at least 3 days prior to needing a refill on my controlled substances to allow adequate time to process the refill request.

____ I am aware that Indiana Health Group does not accept refill requests from my pharmacy.

____ I understand that while taking controlled substances, I must be seen on a regular basis for follow up appointments, typically every 1-6 months but specifically at a frequency as directed by my provider. If I miss an appointment without notifying my provider, my medication may be lowered or stopped.

____ I understand that multiple missed or cancelled appointments could result in termination from the practice.

____ I understand that it is my responsibility to tell my provider if I am, or having reason to believe I am pregnant, as these medications can cause serious harm to an unborn fetus.

____ I will treat the entire staff of Indiana Health group with respect. Rude, disruptive, physical/verbal abuse will result in immediate termination from the practice.

AGREEMENT

I understand all statements above, the goals of treatment, potential risks, and safety policies as outlined above.

I understand that my provider may lower and/or stop my medications if there is no improvement in my symptoms, if there are significant side effects.

I understand that I must comply with my treatment plan and that any violation to the terms of this agreement, may result in the following action(s) being taken:

1**) Controlled substances may no longer be prescribed by any provider at IHG.**

2) Potential termination from the practice.

I agree that all my questions have been answered.

[ ] Patient is a minor: Printed Name of Parent / Legal Guardian: _____

_____ Date: _____

Signature of Patient / Legal Guardian

_____ Date: _____

Signature of IHG Provider / Staff