Bridlewood Family Healthcare

Controlled Medications
Management Agreement

The purpose of this Agreement is to prevent any misunderstandings about any controlled medications that may be prescribed by your provider. This Agreement will help you and your doctor to comply with the law regarding controlled medications.

Each box must be INITIALED to show acceptance of this agreement.

☐ I understand this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

☐ I understand that if I break this Agreement, my provider will stop prescribing these controlled medicines.

☐ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

☐ I will not use any illegal controlled substances, including marijuana, cocaine, etc.

☐ I will not share, sell, or trade my medication with anyone.

☐ I will not attempt to obtain any controlled medicines, including opiod pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider.

☐ I will safeguard my pain or controlled medicine from loss or theft. Lost or stolen medicines will not be replaced.

☐ I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on weekends**.

☐ I agree to use _____ Pharmacy, located at

_____.

Telephone number _____, for filling prescriptions for my pain or controlled medications.

☐ I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

☐ I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain or controlled medicine.

☐ I will schedule an appointment with my provider every month to 3 months and this will be up to the discretion of the provider due to my treatment plan.

□ I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at greater rate will result in my being without medication for a period of time.

□ I will bring all unused pain medicine to every office visit.

□ I understand that if I break this Agreement, my provider will stop prescribing this controlled medicine.

□ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____ day of _____
(month)

_____, _____.
(day) (year)

Print Name: _____ Date of Birth: _____

Patient signature: _____