Bristol
Primary Care LLC

Treatment with Controlled Medications

Patient Agreement

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Treatment with Controlled Medications: Patient Agreement

I,_____, understand and voluntarily agree that

(initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____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.

_____If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I understand that controlled medications are potentially harmful and if not taken as instructed may cause dependency, breathing impairment, coma and death

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____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.

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

_____I will use only one pharmacy to get all on my 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) or stimulants (ritalin, amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____If required I will come in for drug testing and counting of my pills. 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 drugs.

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

_____	_____	_____
Patient Signature	Patient Name Printed	Date

_____	_____	_____
Provider Signature	Provider Name Printed	Date