McLaren Medical Group

CONTROLLED MEDICINES AGREEMENT

The purpose of this Agreement is to prevent any misunderstandings about certain medicines that you will be taking. This is to assist both you and your provider in complying with the law regarding controlled medicines.

TERMS OF THE AGREEMENT:

I understand that my provider is bound by certain state and federal laws when prescribing controlled medicines. While these laws may seem inconvenient to me, I understand that they are ultimately intended to protect my safety, health, and privacy.

I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship. I understand that if I break this Agreement, my provider will stop prescribing controlled medicines.

I understand that this agreement includes all controlled medicines scheduled II-V as categorized by the U.S. Federal regulations. This may include, but is not limited to, drugs referred to as Narcotics, ADD/ADHD Medications, Sleep Medications, Benzodiazepines, etc.

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

I will not use any legal or illegal controlled substances, including marijuana (recreational or medicinal), cocaine, alcohol, and prescription drugs not prescribed by my provider. I agree that I will submit to random drug screenings and random pill counts if requested by my provider to determine compliance with my program of controlled medication management.

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

I will not attempt to obtain any controlled substances, including opioid medicines, controlled stimulants, or anti-anxiety medicines, from any other provider without coordination of care between providers.

I will safeguard my medicine from loss or theft. I understand my provider may not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my medicine, I understand my provider will discuss this with me and may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of controlled medicines. I agree to these additional controls, which I understand include limitations on my supply of controlled medicines.

I agree that refills of my prescriptions for controlled medicines will be made only at the time of an office visit or during regular office hours because an evaluation of my circumstance or condition must be made. No refills will be available outside of normal business hours.

I understand that I may be asked for valid photo ID when picking up my prescription.

I agree to use _____ Pharmacy, located at _____ , for filling prescriptions for all of my controlled medicines.

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

I understand that I am required to see my healthcare provider in a face-to-face appointment at least _____ times per year.

PATIENT
NAME:

DATE OF BIRTH:

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I understand that any provisions not followed in this Agreement is considered non-compliance with this Agreement and may be grounds for dismissal from care.

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

All controlled substances carry the risk of addiction.

This Agreement is entered on this _____ day of _____, _____. _____

Patient: _____ Provider: _____

Authorized Representative: _____ Relationship: _____

Witness: _____

PATIENT
NAME:

DATE OF BIRTH: