Controlled Substance Contract

Patient Responsibility

1) I agree to take any Controlled Substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my Controlled Substances Provider. _____ (initial)
2) I agree to only take Controlled Substances prescribed by _____ (your provider at ERMC Family Practice/Internal Medicine) _____ (initial)
3) I will not take Controlled Substances written by another provider or specialist unless I have notified my provider prior to filling the prescription. _____ (initial)
4) I agree to safekeeping my Controlled Substance prescriptions and medications. I understand that lost, misplaced, or stolen prescriptions or medications will not be replaced. _____ (initial)
5) I will bring in all my Controlled Substance medications in their original pill container to every appointment _____ (initial)
6) I will bring in all Controlled Substance medications in their original pill container for random pill counts within 24 hours of when requested _____ (initial)
7) I will NOT combine any narcotic medication with consumption of alcohol. Any UDS that is positive for both Controlled Substances and alcohol will be considered a violation of this contract. _____ (initial)
8) I will NOT combine any narcotic medication with illegal/street/recreational drugs. Any UDS that is positive for both prescribed Controlled Substances and illicit substances will be considered a violation of this contract. _____ (initial)
9) I will be responsible for making and keeping appointments for Controlled Substance refills at least every 3 months. I understand that NO refills will be written outside of my appointment and I will NOT contact the office for refills of these medications. _____ (initial)
10) I will be responsible for having a working phone number which the office will use to contact me about random UDS and pill counts. I understand that once notified by the office, either directly or by voicemail, I will have 24 hours to report, or inability to do so will result in a violation of this contract. _____ (initial)
11) I understand that not all insurances cover the cost of Drug Screening and that I may be responsible for part or the entire bill. _____ (initial)
12) I understand that I will not receive any Controlled Substances until my provider has been able to review my medical records. If I am a new patient, I understand that it is my responsibility to ensure my medical records have been obtained from my previous provider. _____ (initial)
13) I will not lie or tell misleading information to my provider or any of the ERMC staff. _____ (initial)
14) I will not get angry or make threatening remarks in an attempt to get Controlled Substances _____ (initial)

Provider Responsibility

1) I will Provide the best evidence based care for your condition based on the type of pain you have _____ (initial)
2) I will help set functional and pain control goals with you _____ (initial)
3) I will obtain a random drug screen at least once a year (may be from blood, urine, saliva based on provider discretion) _____ (initial)
4) I will only refill controlled substances at your designated medication refill appointment _____ (initial)
5) I will obtain at every appointment a report from Michigan Prescription Monitoring Program (MAPPS) which shows all controlled substances you have been prescribed including:
    a. Who wrote the script _____ (initial)
    b. Which pharmacy filled the script _____ (initial)
    c. What medication, dose and quantity were filled _____ (initial)
6) I will assess the risk/benefit/safety of your medications including:
    a. Side effects _____ (initial)
    b. Functional abilities _____ (initial)
    c. Pain control _____ (initial)

Consequences of NOT adhering to any part of this Contract:

1) Our office/providers will no longer:
    a. Prescribe any controlled substance for you. It will be at provider discretion to decide if a taper of medication will be given. _____ (initial)
    b. May stop providing medical care for you _____ (initial)
    c. May refer you for drug abuse treatment _____ (initial)

Consequences of NOT signing this contract:

1) We will not prescribe controlled substances for you. _____ (initial)

Should you be discharged from our practice due to breakdown of provider/patient communication, your provider will provide 30 days of care from the date of discharge. This may not apply to Controlled Substances if the reason for discharge was a violation of this contract.

SIGNATURES

Date: _____ Time: _____ Patient Signature: _____

Print First Name: _____Print Last Name: _____

Date: _____ Time: _____ Provider Signature: _____

Print Provider Name: _____