LIFE COAST
COMMUNITY HEALTH CENTER

Controlled Substances Management Agreement

Patient Name: _____ DOB: _____ Chart #: _____

The purpose of this agreement is to prevent misunderstandings about certain medications you may be prescribed. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals.

- I understand that 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 controlled substances.
- If this agreement is violated, my provider will taper off the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my provider about the character and intensity of my condition, the effect of the symptoms upon my daily life, and how well the medication helps to relieve my symptoms.
- I will not use alcohol nor any illegal controlled substance, including marijuana, cocaine, etc.
- I will not share, sell, or trade my medication with anyone.
- I will not attempt to obtain any controlled substances from any other person or provider.
- I will safeguard my medication from loss or theft. **Lost or stolen medications will not be replaced.**
- I agree that refills of my prescriptions for controlled substances will be made only at the time of scheduled office visits or during regular office hours. No refills will be available during evenings or weekends.
- If there is a request for early refills on (3) occasions, controlled substances will be discontinued.
- I understand that consecutive missed appointments may result in disruption of services.
- I agree that I will not operate machinery or drive a vehicle until the exact effects of my medications are established.
- I agree that I will submit a blood or urine test if requested by my provider to determine my compliance with the Controlled Substances Agreement and to determine the use of other controlled substances. I understand that if I fail to pass this drug screen, my provider has the right to discontinue my care at Life Coast Community Health Center. I understand that testing positive for drugs, not prescribed by a medical professional, puts me at a high risk for serious complications and indicates that I am choosing to be non-compliant with the treatment recommendations set forth by my provider.
- I agree that I will use my medications at a rate no greater than the prescribed rate and that use at a greater rate will result in my being without my medications for a period.
- I will bring all unused controlled substance to every office visit.
- I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.
- I understand and agree that if placed on a Controlled Substance the duration of this prescription will be determined by the provider. I will not stop this medicine until I have discussed my short- and long-term treatment goals and a plan with my provider. I will discuss with my provider my prescription and alternative treatment(s) that may be a good fit for my condition.
- I understand that my provider will not prescribe benzodiazepines if I am taking or plan to take opioids, as this is associated with increased risk if fatal overdose.

I agree to use _____ *Pharmacy* at _____ (location)

City _____ Phone# _____

Date of Agreement _____ Patient Signature _____

Parent/Guardian Signature _____

Provider Signature/Title _____

Original to Chart ***Copy to Client/Parent/Guardian*** Revised 12/2020