Avera Controlled Substance Prescribing Agreement

The purpose of this agreement is to give you information about the medications you will be taking for your condition and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using controlled substances.
The long-term use of substances such as opioids (narcotic pain medications), benzodiazepines (klonopin, xanax, valium), stimulants (ritalin, amphetamine), sleep aids, and barbiturates is controversial because of uncertainty regarding the extent to which they provide long-term benefit.

You understand all controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. The Prescription Drug Monitoring Program (PDMP) may be monitored to assess compliance with this agreement.

You will use only one pharmacy to get all of your medicines:_____

Pharmacy name/phone#

You will keep the medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, you understand it will not be replaced until your next appointment, and it may not be replaced at all.

You will take your medication as instructed and not change the way you take it without first talking to the physician or other member of the treatment team. You will not stop your medication abruptly.

You will not call at night or on the weekends for refills. You understand that prescriptions will be filled only during scheduled office visits with the treatment team. No prescription will be provided after __ p.m. _____ or on weekends. Early refills will not be given. Allow at least 24-48 hours' notice to fill your prescription or you may not receive your prescription when needed.

Continued treatment is contingent on following through with treatment recommendations and keeping all scheduled appointments. You understand dosage adjustments will only occur at scheduled appointments. If you are unable to keep your appointment, we request that you give a minimum of 24 hours or 1 full business day notice prior to your appointment. If you miss two appointments or repeatedly cancel appointments with less than 24 hours or 1 business day notice, you may be considered for dismissal from our clinic.

You will see your physician at least __ times per year to review your agreement and determine symptom control.

You will treat the staff at the office respectfully at all times. You understand that if you are disrespectful to staff or disrupt the care of other patients your treatment will be stopped.

You will not sell this medicine or share it with others. You understand that if you do, your treatment will be stopped.

Your signature below allows your physician to speak to all other physicians and/or providers that you see.

You will tell your physician about all other medicines that you take, and let him/her know right away if you have a prescription for a new medicine. **You understand that if you don't, your treatment may be stopped.**

You will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. You understand that if

you do, your treatment may be stopped. Concerns of an overdose or for other substance abuse as well as issues with law enforcement related to the controlled substances prescribed will also result in termination of this contract.

Depression screening will take place at your routine visits, as untreated depression can lead to worsening of your symptoms.

Unannounced urine or serum toxicology screens will be requested at random and at least once yearly. Random medication counts might be requested as well. Your cooperation is required. Presence of unauthorized substances may result in termination of this contract. Any missed tests will be considered positive for drugs. You might be required to pay for this service if your insurance doesn't cover it.

You understand that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms. Any breach of the above contract may result in termination of this contract.

Pain Treatment Program Statement

We at _____are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to change your appointment for any reason, we will make sure you have enough medication to last until your rescheduled appointment.

We will make sure that your treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and may test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other physicians or providers you are seeing so that they can treat you safely and effectively.

If you become addicted to these medications, we will assist you in determining treatment options.

By signing below, I affirm that I have read this agreement and understand and agree to all the terms as stated above.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Physician signature	Physician name printed	Date