CONTROLLED SUBSTANCE CONTRACT

INITIAL EACH BLANK AND SIGN AT THE BOTTOM OF THE PAGE

Controlled substance requires close monitoring for safety and its effectiveness. Only one (1) month of controlled substance medication will be written at the time of your appointment with the exception of medication for ADHD.

_____Regular visits are required

_____No early refills

_____No replacement of medication

_____No use of Alcohol

_____No use of illicit drugs

_____No selling or sharing of medication

_____My Provider and one Pharmacy will fill my medication

_____I agree to a random Drug Screen

_____I agree to take prescribed medication as directed

_____I authorize my provider to check the PDMP (Colorado Prescription Drug Monitoring)

_____I will provide all of my previous medical records by my second office visit and I may not be seen until such records are obtained. I recognize it is my responsibility to obtain such records.

_____I understand that controlled medication can cause adverse side effects including dependency. If I suddenly stop or decrease the medication, I could have withdrawal symptoms of which could be life threatening.

_____I understand if I am pregnant or become pregnant, I will cease all controlled substances.

_____I will not drive a motor vehicle or operate machinery if I experience drowsiness, sedation or dizziness.

I authorize Achieve Health and my pharmacy to cooperate with any law enforcement agency in the investigation of possible misuse or diversion of my medication. I agree to waive any privilege or right of privacy or confidentiality with respect to this contract provided to a third party for facilitation of care or initiation of legal action.

I understand that if I violate any part of this contract, including confronting, manipulating or threatening staff by any means will result in cessation of controlled substance medication and I will be dismissed from the practice with a thirty-day notice.

Signature of Client _____ Date_____

Signature of Provider_____ Date_____