Chino Hills Family Medical Group

Patient-Provider Contract

Controlled Substance Medications

This is an agreement between _____ (the patient) and_____ (the medical provider) concerning the use of prescribed controlled substances including, but not limited to, opioid analgesics (narcotic pain-killers), stimulants, benzodiazepine tranquilizers, barbiturate sedatives, and other controlled substance medications used to treat multiple different medical conditions. I understand and acknowledge that individuals that are prescribed these substances could abuse them or allow them to be abused by others and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this agreement as consideration for, and as a condition of, the willingness of the provider whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat my pain or other medical conditions. Further, if I am being prescribed medication for pain, I understand and acknowledge that the medication will probably not eliminate my pain, but it is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I agree that I will inform my medical provider of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
2. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substances are prescribed to me.
3. I agree that I will keep my scheduled appointments to receive medication renewals, which are recommended every 3 months. I agree that if I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.
4. I acknowledge that I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage.
5. I understand that if I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweating, and chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life threatening for the baby.
6. I understand and acknowledge that overdose on this medication may cause death by stopping my breathing; this may be reversed by emergency medical personnel if they know what I have taken. I acknowledge that it is suggested that I wear a medical alert bracelet or necklace that contains this information.
7. I agree to keep Narcan (generic name Naltrexone) in my home in the event of an accidental opioid overdose.
8. If the medication causes drowsiness, sedation, or dizziness, I understand and agree that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

9. I understand it is my responsibility to inform the medical provider of all side effects I have from this medication.
10. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing medical provider. I understand that running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication, and may be reasons for the medical provider to discontinue prescribing to me.
11. I understand and agree that refills will **NOT** be given over the phone, after office hours, during the weekends, and on holidays.
12. I agree that all controlled substances must come from a provider in Chino Hills Family Medical Group's office unless I have previously disclosed and it was agreed that one is to be provided by another provider/specialist. I agree to fill my prescriptions at only one pharmacy unless there is a supply issue at that pharmacy that is communicated from the pharmacy to Chino Hills Family Medical Group. I agree not to take any controlled substances, including pain medication, or other mind-altering medication prescribed by any other medical provider without first discussing it with the above-named medical provider. I give permission for the medical provider to verify that I am not seeing other medical providers for controlled substance medications or going to multiple pharmacies.
13. I agree that I will inform my other health care providers that I am taking the controlled substances listed above, and of the existence of this Agreement. In the event of an emergency, I agree that I will provide the foregoing information to emergency department providers.
14. I agree that my prescribing medical provider and any covering provider in Chino Hills Family Medical Group has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
15. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, I agree that all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.
16. I agree to keep my medication in a safe and secure place. I understand and acknowledge that lost, stolen, or damaged medication will not be replaced.
17. I agree not to sell, lend, or in any way give my medication to any other person. **I understand and acknowledge that the sharing of medications with anyone is absolutely forbidden and is against the law.**
18. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant of their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
19. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
20. I agree not to alter my medication in any way, and I agree that I will take my medication as prescribed and it will not be chewed, crushed, injected, or snorted.
21. I understand that failure to adhere to these policies and/or failure to comply with the medical provider's treatment plan may result in cessation of therapy with controlled substance prescribing by this office or referral for further specialty assessment, as well as possible discharge from the practice.
22. I agree not to drink alcohol or take mood altering drugs while I am taking controlled substance medications. I agree to submit a urine specimen at any time that my medical provider requests and I give my permission for it to be tested for alcohol and drugs.
23. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

24. I understand that there is a small risk that opioid addiction could occur. This means that I might become physiologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. I understand that people with a history of alcohol or drug abuse problems are more susceptible to addiction. I understand that if this occurs, the medication will be discontinued, and I will be referred to a drug treatment program for help with this problem.
25. I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the medical provider may discontinue this form of treatment.

_____

Patient Signature

_____

Medical Provider Signature

_____

Date

****15361 Central Ave. Chino, CA 91710 *** 909-393-7171 phone*** 909-393-7676 fax****