Patient Agreement to Controlled Substance Treatment

Patient Printed Name:	_____	Patient DOB:	_____
PCP Printed Name:	_____		

Please read this Agreement carefully, and ask your provider if you have any questions.

This Agreement between myself and ETSU Health is intended to provide important information about the use of controlled substances to help manage my chronic pain and/or related conditions.

I understand that there are side effects to this treatment. Some of these side effects are: allergic reactions; depression; sleepiness; decreased mental ability; itching; difficulty in urinating; nausea and vomiting; loss of energy; poor balance and falling; constipation; decreased sexual desire and function; potential for overdose and death. Care should be taken when operating machinery or driving a car while taking these medications. When controlled substances are used long-term, other concerns include the development of physical dependence and addiction. I understand these risks and have discussed them with my provider.

I understand that ETSU Health will prescribe controlled substances only if the following terms are adhered to:

1. All controlled substance prescriptions must be obtained from my ETSU Health provider or, during their absence, from the covering provider. I will notify the ETSU Health Clinic within 48-hours of my receiving a controlled substance from any other physician or other licensed medical provider. I understand it is against the law to provide false information to my provider to try to obtain controlled substances. I understand it is against the law to visit multiple doctors to try to obtain controlled substances.
2. I will submit urine and/or blood on request for testing at any time, without prior notice. These tests will be used to detect the use of non-prescribed drugs and medications and confirm appropriate use of prescribed ones. I will bring my medications to each appointment. I will submit to pill counts, without prior notice. I will pay any portion of the costs that result from urine and blood testing that is not covered by my insurance.
3. I will fill my controlled substance prescriptions at one pharmacy. This pharmacy is authorized to release a record of my medications to this office upon request.
   The pharmacy that I have selected is: _____
   The pharmacy phone number is: _____
4. I understand an office appointment with my provider is necessary to obtain refills for controlled substance prescriptions. I understand that if I take my medications more often than prescribed then I will "run out" early. If this happens my medications will not be filled early. I understand that it is my responsibility to ensure that I leave the office with an appointment consistent with my medication supply. I understand that if I need to call in to make an appointment for a refill, I will give my provider at least three business days' notice. Accidental destruction, loss of medications or prescriptions will not be a reason to refill medications or rewrite prescriptions early.
5. I will guard my controlled substance medications from use by family members, children or other persons. I understand it is against the law to share my medications with others.

6. I understand that I must take my medication only as prescribed and only as a part of a comprehensive treatment plan to manage my chronic pain and/or related conditions. I will not change the amount or dosage frequency without prior approval from my provider except to discontinue the medication in the event of allergic reaction.
7. I understand that I must tell my provider about all other medications, including over the counter treatments that I am taking. I understand I must immediately inform ETSU Health of any new medications or treatments.
8. **For Women of Childbearing Age with Reproductive Capacity (under Tennessee law ages 15-44):** If I plan to become pregnant or believe that I have become pregnant while taking controlled substances, I will immediately inform my ETSU Health clinic. I understand that these medications may cause harm to a baby, and that there are birth control options available to me to reduce the chances of becoming pregnant.
9. I understand that I may be referred at my provider's discretion to other care providers to evaluate my physical or mental condition, or to review my medication needs. Other providers I may be asked to see include but are not limited to Pain Medicine specialists, Psychiatrists, and Physical Therapists.
10. My provider may discontinue or adjust my medications as needed.

I understand that I am responsible for meeting the terms of this Agreement and if I fail to do so my provider may refuse to prescribe controlled substances as part of my treatment. In certain instances I may be dismissed from ETSU Health if I fail to meet the terms of this Agreement. Grounds for dismissal from ETSU Health include, but are not limited to: evidence of recreational drug use; drug diversion (selling or giving drugs to other people); altering prescriptions; obtaining controlled substances from other providers without notifying ETSU Health; abusive language toward staff; engagement in criminal activities, etc.

Continued use of controlled medications is based on my provider's judgment and a determination of whether the benefits to me of using controlled medications outweigh the risk of using them. My provider may discontinue these medications at their discretion. My provider may require more frequent visits. I understand when controlled medications are used properly, they can help restore comfort, function, and quality of life. However, controlled medications may have serious side effects. I understand it is important for me to work with my provider and communicate openly and honestly with them about my medical conditions and the medications used to manage them.

By signing below, I confirm that I have read and understand this Agreement, and that I had the opportunity to have this Agreement explained to me. I confirm that I have had the opportunity to ask questions and that all my questions have been answered. By signing below, I confirm I will follow the terms in this agreement and agree to move forward with the treatment plan as discussed with my provider.

You should NOT sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit in to your pain management treatment plan.

Patient Signature:	_____	Date:	_____
Physician Signature:	_____	Date:	_____
Witness Signature:	_____	Date:	_____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

_____.