

Treatment with Opioid/Controlled Medications and Stimulants

Patient Agreement

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and voluntarily agree that (initial each statement after reviewing):

\_\_\_\_\_\_I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

\_\_\_\_\_\_I will take my medication as instructed and not change the way it is prescribed without first talking to my physician at Family Centered Healthcare, PA.

\_\_\_\_\_\_I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office hours or through my patient portal with Family Centered Healthcare, PA.

\_\_\_\_\_\_I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of Family Centered Healthcare, PA immediately. I will keep (and be on time) for all of my scheduled appointments with Family Centered Healthcare, PA.

\_\_\_\_\_\_I will not sell this medicine or share it with others. I understand that if I do, my treatment will be discontinued.

\_\_\_\_\_\_I will tell the doctor all other medications that I take, and let him/her know right away if I have a prescription for a new medication.

\_\_\_\_\_\_I will use only one pharmacy to get all of my prescriptions:

Pharmacy Name/ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ I will not get any opioid pain medication or stimulants without telling a member of the treatment team before I fill that prescription.

\_\_\_\_\_\_I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines (unless prescribed). I understand that if I do, my treatment may be stopped.

 \_\_\_\_\_\_I will come in for drug testing and counting of my pills within 24 hours of being contacted. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

Continued to back

\_\_\_\_\_\_I understand that I may lose my right to treatment at Family Centered Healthcare, PA if I break any part of this agreement.

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Patient’s signature Printed Name Date

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Physician’s signature Printed Name Date

I have read this agreement and it has been explained to me by my provider at Family Centered Healthcare, PA and/or their staff, and I fully understand the consequences of violating any of the terms of this agreement.