David Barney Family Medicine
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Controlled Substances Contract

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

_____ I will keep my scheduled appointments with the provider and understand that I may not get my prescription if I miss an appointment.

_____ I will keep my medicine safe, secure and out of the reach of children. If my medicine is lost or stolen, I understand it may 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 I take it without first talking to the provider or other member of the treatment team. I will not page the provider at night or on the weekends for refills.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see. I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all my controlled medicines.

_____ I will not get any opioid pain medicines or other controlled medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) from another provider. I understand that the only exception to this is inpatient treatment or with written permission from my PCP.

_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. 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 called. 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.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at David Barney Family Medicine are making a commitment to work with you and we agree that:

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

We will make sure that this 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 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 doctors or providers you are seeing so that they can treat you safely and effectively.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

_____	_____	_____
Patient Signature	Patient name printed	Date