CrescentCare
A Partnership for Life

Controlled Medication Agreement

TO THE PATIENT: *The purpose of this Agreement is to prevent misunderstandings about certain medicines you are currently prescribed or may be prescribed in the future. This agreement helps both you and your health care practitioner comply with the controlled medication laws while also providing you with the best care possible. This Agreement applies to my use of any and all medication(s) including prescription medications, stimulants, painkillers, and opioids/ narcotics.*

I UNDERSTAND AND AGREE TO THE FOLLOWING IF PRESCRIBED CONTROLLED MEDICATION:

- There are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided at or through CrescentCare if I follow the rules specified in this Agreement.
- My provider may at any time choose to discontinue the medication(s).
- If I don't comply with any of the following guidelines and/or conditions, it may cause discontinuation of my medication(s) and/or my discharge from care, treatment, and service delivery at CrescentCare.
    - My involvement in criminal activity may also lead to my discharge from CrescentCare.
    - For certain medications, I understand that my practitioner will reduce the amount and/or strength of the medicine over a period of time to avoid withdrawal symptoms and that a drug-dependence treatment program may be recommended.
    - I will notify my CrescentCare provider of all medications I use, such as prescriptions, over-the-counter medications, or herbal remedies, including those that I take at any time, prescribed by any provider.
    - I will not attempt to obtain any controlled medications from another provider or source, including controlled opioid pain medication, stimulants, or anti-anxiety medications.
    - Medication may only partially treat my condition. I will actively participate in other referrals or treatments, including talk therapy, support groups, and relaxation techniques my provider recommends for managing the condition being treated.
    - I will use my medication(s) only in the manner and at the dose prescribed for me.
    - I understand that no early refills will be given, even if I run out of it before it can next be safely prescribed by the provider, or if the prescription or medication is lost or stolen.
    - I understand that I should only request refills when I am down to my last 2-3 doses and I should not save/store/collect/hoard pills.
    - I agree to come to CrescentCare with my medication for a pill count within 24-hours of when I am called to determine proper usage of my medication.
    - I understand that my information will be monitored on the Prescription Monitoring System to decide if I am taking my medication according to controlled substance laws and regulations.
    - I am responsible for my medication and will store it in a secure location.
    - I understand that taking prescription medications that have not been prescribed to me or giving/selling/trading my stimulant medication to other people, is against the law.
    - I understand that my provider may request a urine and/or blood screening test prior to starting a controlled medication.
    - I agree to take random urine and/or blood screenings, and other diagnostic testing if requested by my provider to show whether I am following our treatment plan. Depending on the results of the screening/tests, I may or may not be able to continue to receive prescriptions for my controlled medication. I understand that I am required to

complete drug screening within 48-hours of my provider's request and that failure to do so may result in discontinuation of my medication.
- I will not alter my prescription, obtain duplicate prescriptions from more than one provider, or use deception to obtain a prescription.
- I understand that I may not be prescribed a controlled medication if I develop a medical or mental health condition to which this medication is contraindicated (in other words, may have an unintended, negative impact to my health or wellbeing).
- I will abstain from illegal/illicit substances and from controlled substances not prescribed to me due to the potential for serious risk to my health.
- I understand I must not drink alcohol or take illicit substances while taking controlled medication because doing so can cause a serious risk to my health.
- I understand there is the potential for developing a tolerance to controlled medications and this makes them less effective over time.
- I understand there is the potential for developing a severe physical or psychological dependence or addiction to controlled medications.
- **(If applicable)**: I will inform my provider immediately if I become, or plan to become, or suspect that I may be, pregnant.

I CERTIFY AND CONSENT TO THE FOLLOWING IF PRESCRIBED CONTROLLED MEDICATION:

- I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
- No guarantee or assurance has been made to me as to the results that may be obtained from treatment. With full knowledge of the potential benefits and possible risks involved, I consent to treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
- I have reviewed the side effects of the medication(s) that may be used in my treatment. I fully understand the explanations regarding the benefits and the risks of these medication(s), and I agree to the use of these medication(s).
- I hereby authorize and direct my practitioner to administer or perform the medical treatment described above in this Agreement, and I hereby consent thereto.
- I have read and understand all information this Controlled Substance Agreement, including any attachment(s), and all blanks were filled in prior to my signing. This Agreement shall remain valid until revoked.
- I have had the opportunity to ask any questions about the medical treatment described above in this agreement, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction. A copy of this document has been given to me.