DOGWOOD
FAMILY MEDICINE

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Controlled Substance Agreement

Patient Name: _____ **DOB:**_____

This agreement provides clear guidelines regarding prescribing practices involving controlled substances from the offices of Dogwood Family Medicine. These regulations are structured to follow guidelines set forth by the North Carolina Medical Board with the main intention to ensure the safety of patients receiving the medications as well as the General Public. If there is a deviation from these guidelines, the practice will conduct an administrative review and reserves the right to discontinue prescribing of any further controlled substances.

The medications covered in this contract include:

Medication	Dose	Directions	Qty/ Month

Please initial each of the following guidelines after reading:

_____. I understand that as a patient of this practice I will be required to take my medication as prescribed, and changes must be approved by my provider.

_____. I understand that I am responsible for my medication and that any lost, misplaced or stolen prescriptions **will not be replaced for any reason**.

_____. I understand that there will be no early refills of these medications if I'm having problems with any prescription, I must make an appointment with my provider to discuss the issue.

_____. I understand I must be seen in the office **in person every three (3) months** per the North Carolina Board of Pharmacy.

_____. I understand that if I receive any other controlled substances from another provider, I must immediately notify Dogwood Family Medicine. This includes codeine or hydrocodone containing cough syrups and medications like Tramadol or Tylenol with codeine. I must make any other provider aware that I'm under a controlled substance contract with Dogwood Family Medicine.

_____. I understand that I must use one Pharmacy and will notify my primary care provider if I change pharmacies. My Pharmacy is: _____
(Please write in your pharmacy)

_____. I understand that I may be drug tested at any time. The cost of the drug testing is my responsibility. Failure of a drug test (including indicators that the prescribed medications are not being taken, the presence of controlled substances not prescribed to me, the presence of alcohol or any illicit drug including marijuana) **will constitute a violation of this agreement.**

_____. I understand that I may be subject to random pill counts. I understand that if I receive a call from the medical office or my provider asking me to come in for a pill count, I'm required to present to the designated office within 48 Hours of the phone call with the remainder of the medication(s) covered under this contract. Each medication will be counted with the expectation that the number of remaining pills will be consistent with the prescribed usage. My best contact number is: _____. If I am unavailable at the time of the call, I will ensure that I will return the phone call at my earliest convenience. Failure to return the phone call, failure to present to the clinic within the designated time, or discrepancies in the number of prescribed medication(s) ***will constitute a violation of this agreement.***

_____. I understand that my provider may stop prescribing or change the treatment plan at any time if I do not show improvement, if I fail to show up for my appointments or if I violate any portion of this contract.

Comments:

_____

_____

_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____