INTEGRATED HEALTH & WELLNESS SERVICES, LLC

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Patient Responsibility Agreement for Controlled Substance

I understand that the main treatment goal using controlled substance is to reduce the symptoms to a bearable level and improve the quality of my life. This includes the ability to function in school, home and/or work.
I understand that in many cases, the symptoms may not be eliminated. In consideration of this goal, and because I am being given a prescribed medication to help me reach my goal, I agree to commit myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my provider.
I understand that my lifestyle and commitment to treatment contributes to a successful outcome.

PATIENTS' RESPONSIBILITY

- I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it will not be replaced.
- I give permission for my provider to discuss all my diagnostic and treatment details and collaborate with others involved in my care and with my pharmacists for purposes of maintaining safety and accountability.
- I will use only one pharmacy for all my prescription refills. I will register the name and phone number of this pharmacy with my providers.
- I know that telephone refills are not allowed. Calls or faxes from pharmacies to refill medications will not be authorized.
- I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the state laws while taking the prescribed medications.
- At any time while I am receiving controlled substance medications, ongoing and continuous evaluation will be made to determine risk for dependence. I understand that if I am determined at risk for dependence, my medications may be tapered to completion.
- I will comply with random PILL COUNTS. These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a violation of this contract and thus will result in discontinuation of controlled medications and may include termination from the practice.
- I agree to undergo random urine drug testing at the discretion of the practice. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or

the absence of my prescribed medications will be considered a violation of this contract and therefore lead to discontinuation of all controlled substance including dismissal from the practice.

- I will not request or accept controlled substance medications from any other provider or individual while.
- I am receiving such medications from this practice. I will not give, share, or sell my medications to any other person.
- I also understand that I must maintain a primary care provider. My primary care provider will be used to care for my other medical needs and in special cases were approved by my primary care provider will prescribe my medications.

- **REFILLS OF MEDICATIONS**
- Will be made only during regular office hours Monday through Friday, in person. This will be done monthly, bi-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.
- Will not be made if I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication as prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid theft.
- Will not be made as an "emergency" either because weekend/holiday is approaching. I will call and allow at least 72 hours in advance to schedule an appointment for refills.

RISKS OF THE CHRONIC CONTROLLED SUBSTANCE USE

I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my provider will advise me of any advances in this field and will make treatment changes deemed appropriate. I am aware that tolerance to controlled substance means that I may require more medicine to get the same effect. If this occurs, increasing doses may not always be effective and safe. Tolerance or failure to respond to controlled substances may require my provider to choose another form of treatment. I am aware that if I plan to get pregnant (female patients only) or believe that I have become pregnant while taking medications, I will immediately call and inform my provider and the obstetrician. I am aware that there could be some adverse effects on my baby. I have been fully informed by provider or the staff regarding the potential for dependence (addiction) of controlled substance medications.

Physical dependence can occur even after using medication for a short period of time therefore, when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. My provider is not responsible for withdrawal syndrome if the medications are used inappropriately.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications maybe be terminated immediately, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my providers, medical facilities, and appropriated legal authorities when demanded. I am responsible for any withdrawal effects that may occur to do my misuse of the controlled medications and/or termination of my care. I have read this contract and the

same has been explained to me by the provider or the staff. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Date_____ Patient_____ Staff Member _____

☐ Copy given to pt. ☐ Pt refused copy. Date _____ by _____