THOMAS HEALTH
AN AFFILIATE OF WVUMedicine

THOMAS HEALTH ORTHOPEDICS ON CHESTNUT ST.

610 Chestnut Street
South Charleston, WV 25309
Phone / 304-767-7790

Controlled Substance Treatment Agreement

The purpose of this agreement is to explain what is expected of you, the patient, while you are receiving prescriptions for controlled medications from your physician.

Please read and initial beside each statement below and sign this form acknowledging your agreement.

_____ I understand that the goal of treatment is to reduce pain, increase my ability to do functional work, and improve my quality of life.

_____ I understand that it is my responsibility to follow the guidelines contained in this consent.

_____ I will speak truthfully with my physician about the type and intensity of my pain, how my pain affects my daily life, and how well the medicine helps to relieve the pain.

_____ I will not use any illegal substances, including marijuana, cocaine, heroin, meth, etc. I will not use alcohol (including beer, wine, & whiskey) while taking controlled medications.

_____ I will not share, sell, or trade my medications with anyone. I understand that if my physician becomes aware that I am sharing, selling, or trading my medications, then my physician has the right to contact law enforcement.

_____ I will take my controlled medications exactly as prescribed by my physician and I will not change my dose on my own.

_____ I will not attempt to get any prescriptions for controlled medications, including pain medicines, stimulants, or nerve medicines from any other physician unless an emergency.

_____ I will notify my prescribing physician within 72 hours of any emergency where I am prescribed a controlled medication.

_____ I understand that I am responsible for my medications and will provide a safe, secure place to keep my controlled medications. I understand that lost or stolen medications will not be replaced.

_____ I agree that prescriptions for controlled medications will be written only at the time of my regularly scheduled appointments as planned by my physician. Prescriptions for controlled medications will not be refilled by phone or at urgent care visits.

_____ I understand that repeatedly calling for refills of controlled medications, harassment of my physician or staff, or aggressive behavior towards my physician or any of the staff may results in discontinuation of controlled medication or dismissal from the practice.

I agree to use _____ pharmacy located at _____

Telephone number _____ for filling prescriptions for all my controlled medications.

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I authorize my physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my physician to give a copy of this consent to my pharmacy.

I agree that I will provide a blood or urine sample for drug testing if requested by my physician. I understand that if I do not provide blood or urine samples, if my physicians finds unauthorized or illegal substances in any sample I provide, or the absence of prescribed controlled medications in any sample I provide, then my physician may change my treatment plan, which may include stopping the prescribing of controlled medications or dismissal from the practice.

I agree to random, periodic pill counts when requested by my physician. If I fail to come in for a random pill count, or if there is discrepancy in the pill count, then my physician may change my treatment plan, which may include stopping the prescribing of controlled medications or dismissal from the practice.

I understand that if I break this agreement, my physician may stop prescribing controlled medicines, and may dismiss me from the practice. In this case, my physician may, but not always, taper me off the medicine as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient Name Printed: _____ Patient Date of Birth: ____/____/_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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