Controlled Substances Agreement

I, _____, agree to the following rules and conditions regarding refills of prescribed medications.

The medication(s) covered by this agreement include:

MEDICATION	DOSE	DIRECTIONS	QUANTITY PER MONTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. I will limit my dose of medications to the dose prescribed. I will discuss any future changes in my dose with my provider during an office visit.
2. I am responsible for my medications. Lost, misplaced or stolen prescriptions will not be replaced.
3. Refills will be made only at the prescribed level. No early refills will be authorized.
4. No refills will be authorized after-hours, on holidays or on weekends.
5. I will obtain all refills through McKinney Family Medicine during the hours of 8am-5pm Monday-Friday.
6. I will obtain all refills for these medications only at _____ pharmacy, located at _____.
7. I will not request any pain medications or controlled substances from other providers and will inform providers of McKinney Family Medicine of all other medications I am taking.
8. I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In the event of any emergency, I will provide this same information to the emergency department providers. If I receive pain medications from another facility, I will notify McKinney Family Medicine within 3 business days.
9. I understand that failure to comply with any of these conditions or failure to make regular follow-up appointments with my provider may result in termination of prescriptions for the medications listed above and possible permanent termination of the patient from McKinney Family Medicine.

Signed: _____ Date: _____