



**7692 Eldorado Parkway**  
**McKinney, TX 75070**  
972.562.8388 (Phone)  
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### **Controlled Substances Treatment Contract**

You, or your minor child, have been prescribed one or more controlled substances that may include stimulants, narcotics, sedatives, benzodiazepines, and barbiturates. I agree to comply with the following rules, regulations, and stipulations:

1. I will use my medication exactly as prescribed. If I am unable to do so, I will notify my provider immediately. Any changes in my prescription will need to be addressed during an office visit. Regular scheduled office visits at least **every 3 months** will be required to obtain prescription refills.
2. I understand that my RX from MFM is for me only, and if I am found taking someone else's or sharing this RX with anyone else; I will be terminated from MFM.
3. I understand that refills will be authorized in the quantity determined by McKinney Family Medicine (MFM) policy. No early refills will be authorized.
4. I will obtain all refills through MFM during regular office hours. No refills will be authorized after-hours, on weekends, or on holidays. Refill requests must be made **48 business hours** prior to being sent electronically to your pharmacy. I will fill my prescriptions using only the exact pharmacy specified in my medical record. I will promptly notify my MFM provider if I change pharmacies.
6. I will not request or obtain any pain medications or controlled substances from other providers and will inform my MFM provider of ALL medications that I am taking. If I do receive pain medications or controlled substances from another provider or facility, I will notify **MFM within 3 business days**.
7. I will inform my other healthcare providers that I am taking these medications and of the existence of this contract. In the event of an emergency, I will provide this same information to the emergency healthcare providers.
8. I understand that if my need for controlled substances exceeds MFM's policy, I may be referred to a pain management specialist, psychiatrist, or other healthcare professional and subsequently MFM will no longer prescribe that medication.
9. We will perform a urine/drug test during your 3-month medication check.
10. I understand that according to state law, MFM is required to run a report through the Texas Prescription Monitoring Program prior to every controlled substance prescription that is dispensed.
11. I acknowledge that I have been counseled on the side effects of the medication that has been prescribed. These side effects include addiction, abuse, tolerance, and withdrawal symptoms. I have also been counseled on strategies to avoid these potentially addictive effects and to notify McKinney Family Medicine immediately should they occur or if I should have any questions or concerns.
12. Failure to adhere to the above policy or any suspected misuse and/or abuse (including lost, stolen, misplaced or destroyed partial or whole prescriptions) of the above policies may result in termination from McKinney Family Medicine. Unacceptable complaints and/or behavior will be construed as abuse.

I have read the above Controlled Substances Contract. I understand that failure to comply with the statements contained within constitutes grounds for my family's dismissal from McKinney Family Medicine. I also understand that any suspected abuse reported by or to the clinic staff constitutes grounds for my family's dismissal from McKinney Family Medicine. I have been offered a copy of this signed agreement, and it will remain in effect indefinitely.

**Signature:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_