Controlled Medication Agreement

PURPOSE: The purpose of the Controlled Medication Agreement is to prevent misunderstandings about certain controlled medications you will be taking for pain, anxiety or ADHD management. This is to help both you and your physician (Fazal Rahim M.D.) to comply with the law regarding controlled medications. I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes to treat me based on this Agreement.

VIOLATION: I understand that if I break this Agreement, my provider will stop prescribing these controlled medications, and maychoose to taper me off of my medications or discontinue medications and prescribed medication to treat the withdrawal symptoms. This choice will be made my provider.

COMMUNICATION: I communicate fully with my provider about the character and intensity of the pain, the effect that my pain has on my daily life, and how well the medication are helping to relieve my pain.

ILLEGAL DRUGS PROHIBITED: I will not use illegal drugs, including marijuana, heroin, cocaine, ECT.

DRUG DIVERSION PROHIBITED: I will not share, sell or trade my medications to anyone. Altering a presciption in any manner, selling medications or misrepresenting myself to pharmacy is a felony and will be reported to police.

SINGLE PROVIDER: I will not attempt to obtain controlled medications, controlled stipulants or anti-anxiety medications from any other physician.

PROTECTING MEDICATIONS: I will safeguard my medications from loss or theft. Lost or stolen medications **will not** be replaced. To reduce instances of medication loss/theft, carry only the amount of medications that you are using when away from home.

I agree to use the following pharmacy for all of my controlled medication prescriptions:

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PRINT NAME OF PHARMACY, ADDRESS, AND TELEPHONE NUMBER

REFILLS: I agree that request for renewals of my prescriptions for pain, ADHD and anxiety medications will be made at the time of an office visit or during regular office hours of my provider. If you fail to come to a scheduled appointment without notifying us prior to that appointment you will not be given a refill until you are seen. **No renewals will be available under any circumstances during the evenings, holidays or weekends.**

PERMISSION TO CONTACT PREVIOUS PHYSICIAN OR PHARMACY: I agree that my provider or authorized staff member may contactmy previous physician(s) and/or my previous pharmacyto discuss my history and medical care st any time during the course of my treatment.

PRESCRIPTION MONITORING PROGRAM: I am fully aware that my provider review my controlled substance prescription records in the Alabama DEA Prescription Monitoring Program operated by Alabama Board Of Pharmacy at any time during the course of my treatment to determine whether I have obtained prescriptions from other providers.

COOPERATION WITH IVESTIGATIONS: I authorize the provider and my pharmacy to cooperate with any city, state or federal law enforcement agency, including the State Board of Pharmacy in the investagation of any possible misuse, sale, or other diversion of controlled medications. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentially with respect to these authorizations.

DRUG TESTING: I agree to submit to a blood or urine test at my cost if requested by my provider to determine my compliance with my controlled medications. Refual to submit to this test will result in the IMMEDIATE TERMINATION OF MY CARE by the provider.

MISUSE OF MEDICATION: I agree that I will use my pain, ADHD and anxiety medications at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medications for a period of time. Continued misuse of controlled medications will result in termination of my care from this provider.

HOSPITALIZATION: If you are hospitalized while under the care of the provider and have questions for the provider (Fazal Rahim M.D), your hospital nurse taking care of you will call the clinic. You are not to call the clinic when you are hospitalized.

UNDERSTANDING THIS AGREEMENT: I agree that all terms of this Agreement have been fully explained to me and I understand all terms of this Agreeemnt. All my questions and concerns regarding treatment have adequately answered. Copies of this signed Agreement will be placed in my medical record.

THIS AGREEMENT ENTERED ON THIS DATE: ______________________

PATIENT SIGNATURE: ______________________________________

PHYSICIAN SIGNATURE: ____________________________________