INTEGRACARE CLINICS

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (such as narcotics, stimulants and benzodiazepines) are very useful under the right conditions for the control of pain to allow a greater degree of function. We believe that these medications have an important place in the treatment of chronic pain, ADHD and anxiety whether it is from cancer or from other sources. We are supported in this belief by the medical literature as well as the American Academy of Pain Medicine and The American Pain Society along with other professional organizations.

However, these medications have a high potential for misuse and abuse and are therefore closely monitored by local, state and federal authorities (who monitor for misuse of medications by people who sell them or give them to other people). Used properly, they are very effective and have not been shown to cause damage to organs or bodily systems. They can cause adverse effects, as can any medication, including constipation, nausea, vomiting, lethargy, and even death, if not used as directed. To insure these medications are used properly, I understand and agree to the following:

1. **Medication Responsibility**
   If the prescription or medication is lost, misplaced, or stolen, or should I use it up sooner than the dose prescribed, I understand that it may not be replaced. If the medication was stolen and I can provide legitimate police reports to substantiate the circumstances surrounding the medication theft, special exceptions may or may not be made. For lost or misplaced medication or prescriptions, I understand that I assume any and all charges to replace the medication. All financial liability related to the misplaced medication is NOT the responsibility of my provider and most likely will not be paid by my insurance company.

2. **Refills**
   Controlled substance refills will only be made during normal office hours Monday – Friday or by pre- arranged appointments. Refills should be requested at least ***5 days*** prior to needing the prescription filled. Prescriptions will only be filled by the primary prescriber or a pre-arranged (by Williams Integracare) provider if the primary prescriber is on vacation. If the primary prescriber is on their normally scheduled day off, refills will be addressed by my provider when they return. I understand and agree that if I forget to make an appointment, or fail to show for a scheduled appointment, I will forfeit the right to additional refills until I schedule and appear for a new appointment. Refills will not be made at night, on holidays, or weekends. I realize that if I do not follow through with my end of this agreement, I may go through medication withdrawal which can cause anxiety, nausea, vomiting, diarrhea, or other side effects. In addition, my pain may increase.

3. **Primary Prescriber**
   I will not request, seek, or accept controlled substances from another provider unless I am admitted to a hospital or medical facility for an acute medical condition. Should I present to an emergency room, I will notify my treating provider of my arrangement with Williams Integracare Clinic and have my prescribing provider notified. I understand that obtaining such medications from other providers can endanger my health. I agree that the only provider permitted to write prescriptions for my controlled substances is my primary prescriber at Williams Integracare.

4. **Drug Screening**
   I understand that I may be asked to provide a urine or blood sample for screening of both prescribed drugs and illicit drugs at any time. Refusing this will result in violation of this agreement.

5. **Violation of Agreement**
   I understand and agree that if I violate any of the above conditions, or decline to take a medication screen at my provider's request, my controlled substance agreement and treatment may be terminated immediately without any recourse by me. If this contract is violated by obtaining controlled substances from other individuals or sources by dishonest means, or by giving these medications to any other person. I may be immediately reported to local, state, and federal authorities. In addition, I understand and agree that I may also be reported to all emergency facilities within the State of Minnesota, my primary care physician, or other parties associated with my care or otherwise. I hereby waive any legal recourse I might have regarding this; this release of responsibility applies to any and all medical records that may be requested by local, state or federal authorities.

Before signing this agreement, I have been instructed by my health care provider about the potential side effects and benefits of my medications. It is my responsibility, and mine alone, to insure that this contract is strictly adhered to and respected.

This agreement was fully read by me and my questions answered by my provider. I agree to abide by it until I cancel it in writing. At which point no further controlled substances will be prescribed.

Patient or Guardian (Print)	Patient Signature	Date of Birth	Date Signed

Provider (Print)	Provider Signature