2328 N. Interstate Drive, Norman, OK 73072
405.857.2179
405.310.7677
info@medacyhealth.com

Controlled Substances Agreement

Controlled substance medications (opioids, stimulants, some sleep medications, and benzodiazepines) are very useful, but have a high potential for tolerance, dependence, and misuse. Therefore, these medications are closely monitored by local, state, and federal governments. Some can cause withdrawal when trying to discontinue. It is important to talk to your provider when wanting to discontinue for safety purposes.

As a patient of Medacy Health Primary Care, I agree to the following (please initial):

_____**1.** I am responsible for the controlled substance medications prescribed to me. I will keep them in a safe place. If my prescriptions are misplaced, stolen, or if I run out early, I understand this medication will not be replaced regardless of the circumstances.

_____**2.** I understand that if I am prescribed an opioid medication for acute pain, the initial prescription may be written for up to, but **not exceed 7 days,** based on provider assessment. If more opioid medication is needed, I will be required to check in with my provider for reassessment, and may be issued an additional 7 days at the discretion of the provider.

_____**3.** I understand that I will be required to have an appointment every 90 days to evaluate the course of treatment and progress towards treatment objectives for long-term use of controlled substances (opioids, sleep medications, benzodiazepines.) I am responsible for scheduling these appointments and understand that medications will not be renewed under any circumstance if outside of the 90 day requirement.

_____**4.** I understand that I will be required to have an **initial 30 day follow-up** with any newly prescribed, non-acute, controlled substance refills. This will also be required for dose changes or medication changes.

_____**5.** I understand that refills of controlled substance medications will be made only during regular office hours. Requests are required to be made 72 hours in advance. Refills will not be processed on the same day as requested, nights, holidays, or weekends. Refills will not exceed a 30 day supply, and I will be required to request a refill monthly.

_____**6.** I will not increase my controlled substance medication on my own.

_____**7.** I will not get controlled substances from any other doctor or clinic. If I am prescribed another controlled substance, I will let the other provider know what I am taking and I will call Medacy Health Primary Care to discuss the new medication with my provider before taking it.

_____**8.** I understand that my provider may ask for a routine or random urine drug screen if he/she feels that it is necessary. I understand that my insurance may not pay for this test and I will be responsible for the cost of this test.

_____**9.** I understand that there is risk of addiction, physical dependence, and withdrawal from controlled substances. I will not discontinue without talking to my provider so a safe taper can be discussed if it is needed.

_____**10.** I understand that mixing controlled medication with things such as pain medicine, muscle relaxants, alcohol, illicit drugs, or other substances that relax the central nervous system can be dangerous to my health and could result in death.

_____**11.** I understand that this office monitors my access to controlled substances through the Oklahoma's Bureau of Narcotics and Dangerous Drugs Prescription Monitoring Program.

_____**12.** I understand that if I violate this controlled substance contract due to non-compliance, the medication will be discontinued or a safe taper will be prescribed if needed. Termination of services could occur.

_____**13.** I understand that if I disagree with, or fail to check any of the above boxes, this opioid agreement is void, and I will not be prescribed any controlled medications.

I have been fully informed regarding psychological dependence (addiction) of controlled substance medications. I know some individuals can develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and doing so can result in increase in the risk of becoming physically dependent on the medication. If I need to stop this medication, I must do so under medical supervision.

Name of Patient or Parent/Legal Guardian/Authorized Representative

Relationship to Patient if Applicable

Signature of Patient or Parent/Legal Guardian/Authorized Representative

Date/Time of Signature