DENT NEUROLOGIC INSTITUTE

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CONTROLLED SUBSTANCE AGREEMENT

Purpose

The purpose of this agreement is to make you aware of our policy regarding controlled substances which exist in order to provide education regarding controlled substances and maintain compliance with state and federal laws and regulations. You are being asked to sign this agreement in the event that a controlled substance is prescribed for you.

Definition of Controlled Substance

Controlled substances include, but are not limited to: opiate and opiate-like pain medications, sedative-hypnotics, benzodiazepines, barbiturate or barbiturate-like medications, stimulant and stimulant-like medications, some anti-seizure medications, and testosterone supplementation.

Controlled Substance Education

- This treatment may increase my ability to function and/or reduce my pain.
- There are other types of treatments that do not involve controlled substances that include, but are not limited to non-pharmacological therapies, lifestyle changes, and non-controlled medications. I agree to pursue these alternatives if recommended, including treatment for chemical dependency.
- The long-term use of controlled substances is controversial because of uncertainty regarding the extent to which they provide long term benefit.
- I am aware that the following potential side effects of controlled substance medications may apply, but not to all classes of medications. I will inform my provider of any side effects that I have experienced.
    a. Respiratory depression (breathing too slowly), overdose, or even death. Drugs may be hazardous or lethal to those who are not tolerant to their effects, especially children and animals, to which you must keep medications out of reach.
    b. Increased Tolerance (require more medication to get the same effect).
    c. Physical and/or psychological dependence (addiction) may develop. There is also risk of relapse occurring in a person with a prior addiction. Abruptly stopping the medication can trigger symptoms of withdrawal. The extent of this risk is not certain. I agree to inform my provider of any history of alcohol or drug addiction.
    d. **If I am a female of childbearing age, I agree to inform my doctor immediately if there is a possibility that I might be pregnant.** Physical dependence of newborns whose mothers take these drugs during pregnancy and the possible can vary depending on the type of medication.
    e. For male patients, low testosterone levels can occur. This may affect mood, stamina, sexual desire and physical/sexual performance.
    f. Sedation (drowsiness). I agree to follow my providers instructions about engaging in activities that might be dangerous to me such as, operating heavy machinery, driving a motor vehicle, performing tasks on a ladder or any other unprotected height, and taking responsibility for another individual who is unable to care for themself. I understand that driving while my ability is impaired could result in charges such as DUI or DWI.
    g. Memory impairment and cognition.

h. Possibility that the medication will not provide complete relief. If relief is not provided, continuation is contingent on treatment plan.

i. Allergic reaction.

j. Taking more than prescribed, taking multiple controlled substances and/or taking controlled substances with alcohol or other illegal substances including, but not limited to: marijuana, cocaine, heroin, or other similar substances can intensify these risks.

Patient Responsibilities

- I agree to conduct myself in a courteous manner with all of the staff in this office.
- I agree to provide a complete and accurate medical and legal history including current medical treatment, past medical treatment, medications I am currently taking and medications I have taken in the past (prescription, over-the-counter, and herbal supplements), any history of alcohol or drug addiction, or the possibility that I may become pregnant. I agree to complete a pregnancy test if required.
- I agree that I will not sell, trade, possess illegally, stockpile, share, or transport any controlled substances. I understand that if suspicion of this activity is observed or is suspected by my pharmacy, other treatment providers, or the NYS Prescription Monitoring Program, this will be reported to my provider and may result in termination of treatment.
- I agree to safeguard my controlled medication from theft, loss, damage.
- I agree to take my medications as prescribed, using them only for the intended purpose, as these may be highly sought after by others with chemical dependencies.
- I agree that I will not alter my paper prescriptions (if applicable).
- I will not accept any controlled medications from any other health care provider unless admitted to the hospital or with explicit approval of my treating provider as documented in my medical chart.
- I agree to submit to a blood, saliva, urine test, or pill count (medications should be brought in their original containers) whenever requested by my provider, including at appointments and within 48 hours of a phone call request. I agree that I am financially responsible for the cost of this testing, if not covered by my insurance. Consumption of poppy seeds may put me at risk of a false positive drug screen. This practice will consider this a positive for morphine regardless of poppy seed consumption. I will not tamper with this drug testing in anyway. I understand that drug tests may be witnessed. Evidence of non-compliance may result in discontinuation of medication and/or discharge from this practice.
- I agree to allow my provider to communicate openly with my other treating providers and pharmacists. I understand that the possible misuse, sale, or diversion of controlled substances may result in communication and investigation with NYS Board of Pharmacy, the Bureau of Controlled Substances, the Federal Drug Enforcement Agency, and any other city, county, state, and federal law enforcement agencies. I authorize my provider to issue a copy of this agreement to any of these agencies and to my pharmacy. I understand that I am waiving any applicable privilege, right of privacy or confidentiality concerning requests for my protected health information from these agencies.

Medication Refills

- I agree to keep and to be on time for all of my scheduled appointments with my provider in order to receive refills of controlled substances. If an appointment cannot be kept, I agree to contact my provider 48 hours prior to my appointment. No refills will be granted if not seen within a maximum of12 months.
- Unless requesting medications during your office visit, all requests should be made to your pharmacy. If for some reason your pharmacy requests that you contact your provider, requests may be made only during regular office hours, Monday through Friday. Requests will not be honored on nights, weekends, or holidays.

- I understand that I must contact my pharmacy or provider 3-7 days prior to running out of my medication. All prescriptions will be electronically prescribed. If a paper prescription is issued at provider discretion,

my provider is not responsible for any lost or stolen prescriptions. A replacement prescription may or may not be granted at the discretion of the provider.

- Early refills will generally not be granted for any reason including, but not limited to theft, loss, damage unless an exception is warranted by your provider.
- I understand that if I am arrested and/or incarcerated my provider may no longer refill my controlled substances.
- I agree to use one pharmacy only and to always inform my provider of any change in pharmacy.

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1. I understand that my compliance with the terms of this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider's treatment will be based on this agreement. Failure to comply with all of the conditions in this agreement may result in:
   a. Danger to my life and health.
   b. My doctor electing to decrease or to discontinue prescribing any controlled substances. If this occurs, my provider may choose to taper the medicine over a period of several days, to avoid withdrawal symptoms when discontinuing it.
   c. Discharge from my provider's practice.
2. I understand that if I am no longer able to pay for the medication or treatment prescribed for me, I must not hold my provider or Dent Neurologic Institute responsible.
3. The terms and conditions of this agreement have been fully explained to me. All of my questions and concerns regarding both my treatment and this agreement have been answered to my satisfaction. I have been given a copy of this document.

This agreement is entered into on _____ / _____/ _____

DOB: _____

Patient Name: _____

Patient Signature: _____