Treatment Agreement for Controlled Substance Therapy

ARROYO VISTA
FAMILY MEDICINE

I, _____, DOB: _____, agree to comply with the rules in this agreement. I will only take the following medication(s) at the dose and frequency prescribed:

☐ Opioid(s) ☐ Stimulant(s) ☐ Sedative(s), ☐ Other(s):_____

Medication name(s): _____

I agree that Dr. Samuel Landero (including advanced practice providers under his supervision) will be the only physician prescribing the above medication and I will only fill my prescription at the following pharmacy:

_____ _____

Pharmacy **Location**

Controlled substance prescriptions are filled monthly and picked up in-office. Any designated representative picking up on your behalf must be authorized below, present valid photo ID, and sign for the prescription.

AUTHORIZED PRESCRIPTION DESIGNEE(S):

1) Name: _____ **2) Name:** _____

IMPORTANT INFORMATION ABOUT YOUR CONTROLLED SUBSTANCE MEDICATION

At Arroyo Vista Family Medicine, it is of the utmost importance that patients and caregivers have clear communication and follow safe, effective procedures when using controlled substances. Please read the following carefully.

GOALS OF TREATMENT: The goals of controlled substance therapy are to improve your ability to function in daily life and to manage your condition effectively. Medications are only one part of treatment.

EFFECTIVENESS: Controlled substance medications can be effective when used as directed for their intended purpose. However, results vary by individual and condition, and it is possible this medication will not work as expected for you.

SAFETY: Most patients are able to take these medications safely. However, some individuals do experience side effects or interactions. Always inform your provider of all other medications, supplements, and herbal products you are taking before starting or continuing a controlled substance. If you become pregnant while on a controlled substance, you must notify your provider immediately. Use of controlled substances during pregnancy carries significant risks.

SIDE EFFECTS: Side effects vary depending on the type of controlled substance prescribed. Common and possible side effects include:

- ***Opioids/Fentanyl Patch/Codeine:*** Constipation, nausea, vomiting, itching, sedation, lightheadedness, mental slowing, loss of coordination, breathing difficulties (especially with COPD or concurrent narcotic use), decreased testosterone, lowered sex drive, and leg swelling. Pregnant women using opioids risk newborn dependency.
- ***Stimulants:*** Jitteriness, sleep disturbance, anxiety, emotional changes, elevated blood pressure, rapid or irregular heartbeat, decreased appetite, weight loss, and rash.
- ***Benzodiazepines:*** Sedation, confusion, memory impairment, loss of coordination, dependence, and severe withdrawal risk if stopped abruptly. Combining benzodiazepines with opioids, alcohol, or other sedating medications significantly increases the risk of respiratory depression and death.

IMPORTANT SAFETY WARNING: The use of alcohol, or any other non-prescribed mind-altering substance should not be taken with controlled substance medication(s). Even a single controlled substance combined with alcohol or other substances can cause serious harm, including respiratory depression, loss of consciousness, organ damage, and death. This risk increases significantly when more than one controlled substance is prescribed simultaneously.

DEPENDENCE: Dependence is not the same as addiction. Many patients who take controlled substances daily will develop physical dependence, meaning the body has adapted to the medication. If the medication is stopped or reduced too quickly, withdrawal symptoms may occur. These can include moodiness, sweating, aches, nausea, diarrhea, abdominal pain, and in some cases seizures. Never stop your medication abruptly without guidance from your provider.

ADDICTION: Addiction is not the same as dependence. Addiction is characterized by loss of control over drug use, compulsive use and craving, and continued use despite harm to oneself or others. If you have concerns about addiction, please discuss them openly with your provider.

I AGREE TO THE FOLLOWING:

_____(Initials) I understand that I must be seen by my provider at least every **3 months** to continue receiving my controlled substance medication, unless my provider specifies otherwise. Failure to maintain this appointment schedule will result in discontinuation of my prescription.

_____(Initials) I will not change the dose, frequency, or timing of my medication without my provider's authorization, and I will not seek early refills unless a major change in my condition has occurred and my provider has approved it.

_____(Initials) I will report any concerning side effects to my provider promptly. I understand that controlled substances, whether taken alone, combined with alcohol, or combined with other medications, can impair thinking, judgment, and coordination. I will not drive or operate machinery if these effects occur. Use of alcohol or non-prescribed substances while on a controlled substance will result in immediate discontinuation of my prescription.

_____(Initials) I will follow through with all treatments and non-controlled medications as directed, including physical therapy, exercise regimen, counseling, or specialist referrals. I will accept controlled substance medications from my provider only. Failure to comply will result in discontinuation of my controlled substance medication.

_____(Initials) I will not share, sell, or exchange my medications, and I will keep them safely stored and out of reach of children. I will not use illegal substances, including marijuana, or any controlled substance not prescribed to me by my provider. Lost or stolen medications may or may not be replaced. If stolen, I must file a police report and provide the report number to my provider's office. Any replacement will be granted only once. I understand that serious concerns of misuse will be reported to the appropriate authorities.

_____(Initials) I agree to submit to random, unannounced drug testing at any time when requested by my provider. Testing will screen both for the presence of my prescribed medication and for other substances. Failure to comply or unsatisfactory results will result in loss of the right to receive this medication.

_____(Initials) If my provider determines I may have a substance use disorder, I must undergo evaluation by an addiction specialist. If that evaluation confirms a substance use problem, my provider will discontinue my controlled substance medication using a taper to avoid withdrawal symptoms.

_____(Initials) *Opioids/Fentanyl Patches/Codeine*: If a new acute condition develops, I have the right to receive appropriate treatment for that condition from the treating provider and should not increase my chronic pain medication to compensate. *Benzodiazepines*: I understand that suddenly stopping my benzodiazepine medication can be medically dangerous, including risk of seizure, and I will never stop this medication suddenly without my provider's guidance.

_____(Initials) I understand that my provider will reduce or stop my controlled substance medication if I am not following this treatment plan or if the medication is not resulting in improved function or symptom control. My provider is obligated to comply with all state and federal laws regarding controlled substances, including monitoring the Prescription Monitoring Program (PMP) database and communicating with providers, pharmacies, and law enforcement agencies involved in my care or in the investigation of medication misuse.

I acknowledge that the risks and benefits of controlled substance therapy have been explained to me by my medical provider and staff. I agree to comply with all parts of this treatment agreement and understand that failure to comply with any portion of this agreement will result in my provider discontinuing my controlled substance prescription.

_____

Patient's Signature **Date**

_____

Provider's Signature **Date**