Holistic Internal Medicine

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Controlled Substance Contract

I, _____, WILL ADHERE TO THE FOLLOWING GUIDELINES TO RECEIVE CONTROLLED SUBSTANCES FROM HOLISTIC MEDICINE CLINIC:

It is my sole responsibility to safeguard my prescription. If my prescription is lost, stolen or misplaced I understand that my physician will not replace it and I will be dismissed from the practice due to my negligence.

I will only receive the controlled medication from Holistic Medicine Clinic and will not request other forms of controlled substance from any other physician without prior approval from my physician.

I will take medication as prescribed by my physician and will not alter the dose or frequency without prior approval from my physician.

I will only fill controlled medication at one pharmacy. If I wish to change my pharmacy, this information will be relayed to my physician and documented in my medical records.

I understand that an appointment with a physician or clinical staff member is required in order to receive refills on controlled medications. I will not ask for early refills on my medications and will schedule my refill appointments accordingly

I will not request refills on routine controlled medications after hours or over the weekend.

I will consent to a blood or urine drug screen if deemed necessary by my physician.

I will allow my physician to discuss treatment details with other healthcare providers involved in my healthcare.

I, _____, have read and understand the guidelines as described above and agree to uphold them while a patient of Holistic Medicine Clinic. I understand that if I violate any of these guidelines I will be dismissed from the practice. I have listed below the medication I wish to receive and the pharmacy that I will utilize for this medication.

Controlled Medication: _____

Pharmacy: _____

Pharmacy Phone: _____

Prescribing Physician's Name: _____

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date