UB|MD
INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

UBMD Internal Medicine
In Amherst: 1020 Youngs Road
In Buffalo: 1001 Main Street
462 Grider Street

Controlled Substance Agreement

This agreement between _____ (patient name)_____(DOB) and the medical providers of UBMD Internal Medicine (UBMDIM) is for the purpose of establishing clear conditions for the prescribed use of controlled substances. The medical provider and the patient agree that this agreement is an essential factor in maintaining the trust and confidence in the provider/patient relationship. The patient has been informed that individuals who are prescribed certain controlled substances including, but not limited to sedative/hypnotics, pain medications, stimulants, and muscle relaxants can abuse these substances or may allow abuse by others, and have the risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use. I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the medical provider whose signature appears below to consider prescribing or to continue prescribing controlled substances.

1. I will inform my medical provider of any current or past substance abuse, or any current or past substance abuse of any immediate member of my family with whom I have contact.
2. I will discontinue all previously prescribed pain medications unless told to continue them by this practice.
3. I will not use **any** illegal substances.
4. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substances will be prescribed to me. I agree that the need to be evaluated by psychologists and/or psychiatrists may be revisited every three (3) to six (6) months thereafter while taking controlled substances.
   During my medication treatment, I understand that I am also expected to comply fully with all individual treatment recommendations (such as physical therapy, behavioral pain medicine, home exercise, etc.). I understand that failure to keep any scheduled appointments may be interpreted as an act of non-compliance and may result in an involuntary medication taper and/or discharge from this practice.
5. All controlled substances must come from my medical provider at UBMDIM or from a consulting medical provider who is keeping my medical provider at UBMDIM informed of their prescribing practice for my healthcare. In the instance of controlled substances being prescribed after a surgery, hospitalization, an emergency department visit or other emergency, I will report this to my UBMDIM provider within 3 business days.
6. My controlled substances will come from the UBMDIM medical provider whose signature appears below or during his or her absence, by the covering medical provider, unless specific written authorization is obtained from the office for an exception.
7. I agree to use a single pharmacy for all of my medications. I agree to use _____ (pharmacy) located at _____. The pharmacy phone number is (___)_____. If I must change pharmacies for any reason, I agree to notify my provider at the time I receive the prescription and to advise my new pharmacy of my prior pharmacy's address and telephone number. I understand that you and my pharmacy will report my pain medication usage to New York State as required by law.
8. I will inform the UBMDIM office of any new medications or medical conditions. I will also inform the office of any adverse effects I experience from any of the medications that I take.
9. I realize that it is my responsibility to keep others and myself away from harm. This includes driving safely, working safely, and performing all daily activities safely while on my medications. If there is any question of impairment of my abilities, I agree that I will not attempt to perform any activity until I have undergone evaluation with clearance to return to regular activity, or I have not used my medication for at least four (4) days.
10. I will inform my other health care providers that I am taking any of the controlled substances listed above, and of the existence of this Agreement. I will not attempt to obtain controlled medications from any other health care provider without telling them that I am taking controlled medication prescribed by UBMDIM. **I understand that it is against the law to do so.** In the event of an emergency, I will provide the foregoing information to emergency department providers.
11. I realize that all medications have potential side effects, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.

12. I agree that my prescribing medical provider has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
13. I will not share, sell, or trade my medication for money, goods or services. I understand that **Federal Law prohibits the transfer of these drugs to any person other than the patient for whom they are prescribed.** I will not take any other persons controlled substance.
14. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
15. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
16. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
17. I agree not to alter my medication in any way and I will take my medication whole. It will not be broken, chewed, crushed, injected, or snorted.
18. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by a UBMDIM provider.
19. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
20. I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication by a UBMDIM provider. Failure to comply may result in immediate discharge from the practice.
21. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.
22. **I understand that the absence of the prescribed substance may result in my immediate discharge from the practice.**
23. I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I could be without my prescribed medication for a period of time.
24. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report or a statement from me explaining the circumstances may be required before additional prescriptions are considered. If I request an early refill because I had lost, damaged, or stolen prescriptions twice within a year, I may be discharged from the practice.
25. I understand that a prescription may be given early if the medical provider or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.
26. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration. HIPAA requirements will be followed.
27. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.
28. I understand that I may be asked to bring my medications in their original container to the UBMDIM office while I am on controlled medication.
29. I understand that prescription refills will only be made during regular office hours which are Monday through Friday. Prescriptions are only sent electronically directly to the pharmacy that I have specified on this contract. The only exception for paper scripts is when our EHR systems are down. **Refills generally will not be given over the phone, after office hours, during the weekends, and on holidays**.
30. I will call at least seven (7) days in advance of needing a refill of my pain medication. I understand that I am responsible for monitoring my own medication and that not calling within the appropriate time frame may result in me running out of my medication, not having my medication, and **could result in my death.**
31. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and/or a reduction in the intensity of my pain and improve my ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my medical provider believes that the medication usage benefits me.
32. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage. I understand that long-term advantages and disadvantages of chronic opioid use have yet to be significantly determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long-term use of opiate narcotics and that my medical provider will make treatment changes as needed.

33. I understand that failure to adhere to these policies and/or failure to comply with my medical provider's treatment plan may result in cessation of therapy with controlled substance prescribing by this provider or referral for further specialty assessment, as well as possible discharge from the practice.

34. **I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.**

This agreement is entered into on this _____ day of _____, 20 _____.

_____ _____

Patient Signature **UBMDIM Medical Provider Signature**

_____

Witness Signature

I acknowledge receipt of a copy of this agreement on the date stated above.

_____

Patient Signature