I understand that certain controlled medications have the potential for misuse and are therefore closely monitored by Federal regulations. Because my physician is prescribing this type of medication, I agree to the following conditions:

I understand I am responsible for my controlled medications:

- ☐ I understand and agree to take the medication only as prescribed.
- ☐ I agree to seek treatment for my pain/anxiety only from the physicians staffed at the Platte County Health Department, unless referred directly by the Platte County Health Department to another facility.
- ☐ I agree to use one pharmacy and will supply my doctor with the name and phone number of that pharmacy. I understand my doctor's office may contact the pharmacy or other pharmacies if he/she desires information.
- ☐ I understand I will not be given early refills if my medication "runs out early," is lost, dropped down the toilet or sink, eaten by pets, contaminated, stolen, etc.
- ☐ I agree that I will not give or sell my medication to anyone else, and I will not take any other pain or controlled medication(s) without the consent of my physician.
- ☐ I agree to refrain from taking any illicit drugs including marijuana.
- ☐ I am aware that I must disclose if I have a medical marijuana card and seeking treatment with medical marijuana. I also understand that no controlled medications will be prescribed while being treated with medical marijuana.
- ☐ I understand I may be asked by my provider to supply a urine sample for drug testing at any time. I also understand I am responsible for the cost of that testing to be paid that day. If I refuse this testing **NO** controlled prescriptions will be issued.
- ☐ I understand if my urine drug screen is positive I may incur additional cost for confirmatory testing through an outside laboratory (Quest) if requested.

I understand the Physician or FNP will determine the amount of medication to dispense:

- ☐ I agree and understand the importance of keeping my scheduled appointments and will get my prescriptions refilled at that time.
- ☐ If a change in my medication dosing is required, then I understand I must make an appointment to see my doctor regarding those changes.
- ☐ I also agree to keep my referral appointments (for example: physical therapy, mental health, specialists, pain management, x-ray, MRI, CT scans, etc.)
- ☐ I understand that I can call with problems during regular office hours only.
- ☐ I also agree not to use the Emergency Room solely to obtain additional pain/anxiety medication.

I will also provide medical records from my other doctors if requested.

I understand that if I do not follow these conditions, my physician may not refill my controlled substance(s) medication, and may discharge me from this clinic.

Patient Name Printed: _____DOB:_____Date:_____

Patient/Guardian Signature: _____Witness:_____