MINDFULNESS
HOLISTIC WELLNESS & HEALING

Controlled Substance Contract

Patient Responsibility

1. I agree to take any Controlled Substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my Controlled Substance Provider. **____ (Initial)**

2. I will NOT take Controlled Substances written by another provider or specialist unless I have notified my provider prior to filling the prescription. This includes Suboxone, Methadone & Medical Marijuana. **____(Initial)**

3. I agree to safekeeping of my Controlled Substances and medications. I understand that lost, misplaced or stolen prescriptions or medications will not be replaced unless a police report is filed. **____(Initial)**

4. I will bring in all my Controlled Substances in their original container to every appointment. **____(Initial)**

5. I will bring in all my Controlled Substances in their original container within 24 hours of request for random pill counts. **____(Initial)**

6. I will be responsible for making and keeping appointments for Controlled Substance refills at least every 1 month. Terms of appointment keeping are in your Patient Intake Form. **____(Initial)**

7. I will be responsible for having a working phone number on file which the office will use to contact me about random Drug Screens and pill counts. I understand that once notified by the office, either directly or by voicemail I will have 24 hours to report. Inability to report is a violation of this contract. **____(Initial)**

8. I understand that not all insurances cover the cost of Drug Screening and that I may be responsible for part or all of the bill. **____(Initial)**

9. I understand that I will not receive Controlled Substances until my provider has been able to review my medical records. If I am a new patient it is my responsibility to ensure my medical records have been obtained from my previous provider and this practice has results of Initial Drug Screen. **_____(Initial)**

10. I understand it is my responsibility to make sure the Initial Drug Screen has been done. **_____(Initial)**

11. **I will not lie or tell misleading information to my provider to obtain Controlled Substances. _____(Initial)**

12. **I will not get angry or make threatening remarks to ANY provider or staff member in an attempt to obtain Controlled Substances. _____(Initial)**

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Controlled Substance Contract
Provider Responsibility

1. I will provide the best evidence based care for your condition.
2. I will help set functional goals with you.
3. I will obtain a random drug screen at least 4 times a year or anytime we deem necessary.
4. I will only refill Controlled Substances at your designated medication refill appointment.
5. I will assess the risk/benefit/safety of your medications including.
    - Side effects
    - Functional abilities
    - Pain Control

Consequences of NOT adhering to any part of this contract:

1. Mindfulness Holistic Wellness & Healing and our providers will no longer:
    - Prescribe any Controlled Substance for you. It will be at the provider's discretion if a taper of medication will be given.
    - May stop providing medical care for you.
    - May refer you for drug abuse treatment.

Consequences of NOT signing this contract.

1. We will not prescribe Controlled Substances to you.

Should you be discharged from our practice due to breakdown of provider/patient communication, your provider will provide 30 days of care from the date of discharge. This may not apply to Controlled Substances if the reason for discharge was a violation of this contract.

SIGNATURES

Date:_____ Time:_____ Patient/Guardian Signature:_____

Print Patient First Name: _____ Print Patient Last Name:_____

Date:_____ Time:_____ Provider Signature:_____

Print Provider First Name: _____ Print Provider Last Name:_____