(S)FM
Sparks Family Medicine, Ltd
Functional Medicine

Controlled Substance Prescription Medication Agreement

Patient Statement

I, _____,
understand and voluntarily agree that (initial each section after reviewing):

_____ I will be compliant, including:

- Making sure the office has current contact information in order to reach me.
- Keeping (and being on time for) all my scheduled appointments at this office.
- Participating in all other types of treatment that I am asked to participate in.
- Taking my medication as instructed and not changing the way I take it without first talking to the office staff.
- Treating the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.
- Telling the provider all other medicines that I take, and letting the provider her know right away if I have a prescription for a new medicine.
- Using only the pharmacies on record at this office.
- Not getting any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a informing the office staff before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____ I will be responsible in using a controlled substance, including

- Keeping the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.
- Making sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the office staff immediately.
- Signing a release form to let the doctor speak to all other doctors or providers that I see.
- Coming in for drug testing and counting of my pills within 24 hours of being called.
- Informing the provider of treatments received for side effects or complications of medication.
- Not calling between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.
- Not selling this medicine or sharing it with others. I understand that if I do, my treatment will be stopped.
- Not using illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

States I have previously resided or had a controlled substance prescription filled:

_____

_____

_____

_____

To be completed and scanned into the patient's chart at 30-Day CS Rx visit.

Provider Statement

The goals of this treatment plan are:

_____

_____

_____

_____

- This office will terminate patients who do not comply with each of the patient statements on the previous page.
- If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set treatment goals and monitor your progress in achieving those goals.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider Signature: _____

To be completed and scanned into the patient's chart at 30-Day CS Rx visit.