Dunkirk Family Practice
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Controlled Substances Contract

This agreement is between patient and his/her doctor. It is agreed that the controlled substances discussed today, stated in "my medication" in this contract will be given by my physician on a regular basis to me only if the following terms are met: By initialing and signing this consent form for chronic controlled medication administration, I indicated that I understand the discussion about the use of my medication, including all side effects, and agree to start this treatment under the terms set by my doctor.

Initials	Item	Policy
	1	My doctor at Dunkirk Family Practice, PA who has signed below, will be the only doctor of the group and the only one and only source of my controlled medications unless permission is given by my doctor for me to get my prescriptions from another physician.
	2	I will call for refills at least four (4) working days before my medication runs out. I will make follow-up appointments on a routine basis with my doctor at a frequency determined by my doctor.
	3	I agree to take my medications exactly as instructed by my Dunkirk Family Practice, PA physician or in smaller doses. Any unauthorized increases in doses may result in discontinuation of refills. Using higher prescribed doses will not be considered a valid reason for refilling medications early. If I feel I need a higher than prescribed dose, I will schedule an appointment at my earliest convenience in order to discuss this with my doctor.
	4	My medication will not be refilled on weekends and will not be called in to the pharmacy.
	5	I agree to allow my Dunkirk Family Practice, PA physician to communicate with any other doctors or pharmacists regarding my use of controlled substances.
	6	I understand that Dunkirk Family Practice, PA will not replace my lost or inaccessible or stolen prescriptions or medications for any reason. I must pick up my prescriptions in person or send a signed authorization for another person to pick up the prescription, and that person must have a photo identification at the time the prescription is picked up.
	7	I certify or agree to the following: a) I am not currently abusing illicit or prescription drugs. b) I have never been involved in the sale, illegal possession, diversion, or transport controlled substances (narcotics, sleeping pills, amphetamines, nerve pills, or painkillers). c) I am not pregnant and I will appropriate contraception during the course of my treatment, if applicable. d) Any sharing of my medication will result in the immediate cancellation of refills.
	8	Evidence of medication hoarding, increasing amount of medication without communication to my Dunkirk Family Practice, PA physician, refilling too frequently, getting the medications from multiple doctors or pharmacies.
	9	I agree to any evaluation by other physicians, specialists, or specialty clinics deemed appropriate by my Dunkirk Family Practice, PA physician, relative to the use of these medications.
	10	I understand that all controlled medications are prescribed only under the circumstance of having a valid diagnosis and that continued prescription of these medications requires active pursuit of a final diagnosis. Failure to get appropriate tests (including, but not limited to, toxicology screenings) or other evaluations will result in non-refill of these medications.
	11	I understand that my doctor/nurse practitioner is required by law to verify in the PDMP (prescription drug monitoring program) via CRISP (Chesapeake Regional Information System Portal) all of my controlled dangerous substance prescriptions from ANY healthcare professional every ninety (90) days.

This contract has been fully explained to me. I have read it or have had it read to me, and I understand and agree to the terms of this contract.

Date: _____

Patient Name Printed _____ Date of Birth _____

Patient Signature _____ Witness _____

MD/NP _____ Preferred Pharmacy _____