North Texas Family Health
Controlled Medication Agreement

2021 revised

Treatment with Controlled Medications Patient Agreement Form

I understand and voluntarily agree that:

1. I will keep and be promptly on time for all my scheduled appointments with the provider(s) of North Texas Family Health.
2. I will participate in all treatments that I am required to participate in while being treated by the provider(s) of North Texas Family Health.
3. I will keep my prescribed medication(s) safe, secure, and out of reach of children.
    a. If my medication is lost, destroyed, or stolen, I understand that it will not be replaced until my next scheduled appointment and may not be replaced at all.
4. I will take my medication as instructed and not change the way I take it without prior approval from the provider(s) of my treatment.
5. I will not contact the provider(s) or staff of North Texas Family Health in between appointments, at night, on weekends, during off hours, etc. to ask for refills on my medications.
    a. I understand that prescriptions will be filled only during scheduled office visits by the provider(s) of North Texas Family Health.
    b. I understand that I must be evaluated and complete all necessary diagnostic testing prior to being prescribed treatment including prescription medications.
6. I will make sure that I have an established appointment for refills.
    a. If I am having difficulty making an appointment, I will contact North Texas Family Health no later than 5 business days before my next expected refill appointment.
7. I will treat all staff at North Texas Family Health with respect.
    a. I understand that if I am disrespectful to the staff or disrupt the care of other patients at North Texas Family Health, my treatment will be stopped, and I will be terminated from any further treatment from North Texas Family Health.
8. I will not sell or share my prescribed medication(s) to others.
    a. I understand that if I do, my treatment will be discontinued, I will be terminated from any further treatment at North Texas Family Health, and I will be reported for any legal consequences necessary to protect North Texas Family Health, it staff, and providers.
9. I will sign a release form, allowing all providers, whom I am treated by, to discuss my care plan and treatment expectations.
10. I will tell the provider(s) at North Texas Family Health, all of the medications that I take and I will notify the provider(s) when I get a new prescription from another provider or service (including Dentists, Urgent Care, Emergency Departments, and Specialists).

11. I will limit my prescriptions to be filled at no more than two pharmacies unless prior approval was made with my provider(s).
    a. I understand that it is my responsibility to comply with the pharmacy's polices and procedures and that North Texas Family Health is not responsible for the pharmacy's polices.
12. I will not get any opioid pain medication (includes Tylenol with Codeine) or other "addictive", scheduled medications such as benzodiazepines (Ativan, Klonopin, Valium, Xanax, etc.) or stimulants (Adderall, Ritalin, Vyvanse, etc.) without notifying my provider(s) at North Texas Family Health, before filling that prescription(s).
    a. I understand that the only expectation would be if given by an emergency department provider for emergency purposes at night, on weekends, or after hours.
13. I understand that my name will be ran through a nation search to identify recent activity associated with prescribed medications.
    a. I acknowledge that I may not be prescribed medications that have been previously prescribed by another provider.
    b. I understand that I may not be prescribed the same medication, dosage, and/or frequency as previously prescribed by another provider.
14. I will not use illegal drugs (heroin, cocaine, methamphetamines, ecstasy, rohypnol, etc.)
    a. I will not use any medication that is not prescribed to me.
    b. I understand that my use of any elicit drug(s) would result in my treatment being discontinued and I will be terminated from any further treatment by North Texas Family Health.
15. I acknowledge that I will be required to participate in routine drug testing.
    a. I understand that I can be required to be called in for "random drug" testing and/or pill count at the provider(s) discretion.
    b. I will keep my contact information current in order to be reached by North Texas Family Health.
    c. I understand that any missed tests will result in not receiving "refilled" medication(s) and may be considered a "positive" elicit drug result or as noncompliance of treatment.
16. I understand that I will be required to have certain labs and diagnostic tests that must be done routinely to ensure my health and wellness.
    a. I acknowledge that these tests will be my responsibility to pay for and complete in order to continue being treated by North Texas Family Health.
17. I understand that North Texas Family Health is a "for profit" health care provider and it is my responsibility to keep up to date with my account.

18. I understand that I am responsible for this agreement and that I may be terminated from any and all further treatment from North Texas Family Health if any of these terms are violated or neglected.

Controlled Medication Treatment Statement

North Texas Family Health is making a commitment to facilitate your health care by providing the following commitments:

1. We will assist you in scheduling routine appointments to evaluate the effectiveness, compliance, safety, and necessity of your treatment.
2. We will make sure you have enough medication to last until your next appointment ***if we change or cancel*** your appointment for any reason.
3. We will ensure that your treatment is safe and follows the recommendations of State and Federal agencies.
4. We will routinely evaluate the effectiveness, compliance, safety, and necessity of your treatment and make alterations that best facilitate your health and overall wellness.
5. We will evaluate your prescriptions and drug tests regularly to evaluate treatment effectiveness, compliance, safety, and necessity.
6. We will work cooperatively with other providers, specialties, and services to provide a consistent, safe, and effective care plan.
7. We will set treatment goals and monitory your progress in achieving those goals.
8. We will work with your insurance provider(s) and specialized assistance programs to facilitate that you are able to initialize or continue your treatment(s).
9. We will monitor and provider alternative treatments to minimize the potential of developing an addiction to the medications being prescribed.

Your Name: ________________________________ Today's Date: __________________

Your Signature: ____