Arthritis & Rheumatic Diseases, P.C.
329/331 McLaws Circle
Williamsburg, VA 23185
(757) 220-8579

CONTROLLED SUBSTANCE TREATMENT AGREEMENT

I, _____, understand that in order to receive care for the treatment of pain or the use of controlled medication's, I agree to and will comply with the following:

Any medical treatment is initially a trial and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and/or increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.

A. MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the undersigned physician.

B. USE OF MEDICATIONS: I understand that use of such medication have certain risks associated with it, including, but not limited to: sleepiness, drowsiness, constipation, diarrhea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia's, addiction, withdrawal and possibility that the medicine may not provide complete relief.

   I will take all medications as prescribed. **I will speak with the undersigned physician before making any change in either dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Narcotic pain medications must all be obtained from the same pharmacy each time.** Should the need arise to change pharmacies, our office **MUST** be informed and undersigned physician approves the change. I will abstain from alcohol use.

C. SEEKING PRESCRIPTIONS: I understand that only providers at Arthritis and Rheumatic Diseases will prescribe my narcotic medication. I will neither seek nor fill prescriptions for any controlled medication from any other health care provider unless authorized by the undersigned physician. This includes, but is not limited to: hospital discharges, emergency room visits and dental procedures. I will instruct my other physicians to confer with Arthritis and Rheumatic Diseases providers for any changes or need for additional narcotic medications. If it is brought to the attention of Arthritis and Rheumatic Diseases that other providers are prescribing medications for me, Arthritis and Rheumatic Diseases reserves the right to discontinue prescribing medication and/or discharge me from their practice.

   In accordance with FDA state and federal regulations, concerning the prescribing of controlled substances, ALL of our providers, check the Prescription Monitoring Program (PMP) Registry for any patients taking narcotic prescriptions to prevent and detect prescription drug misuse and diversion, and improve patient care through better coordination of care.

   I will not harass or repeatedly speak with the pharmacist about refills which may be early. I will not call my physician after hours about my controlled substance prescription refills.

D. MEDICAL RECORDS RELEASE: I will inform all of my health care providers that I receive pain management and will maintain an unrestricted and current medical records release on file. I will inform Arthritis and Rheumatic

Diseases providers of any changes in my medical condition, any changes in any prescription and/or over the counter medications that I take and any adverse effects I may experience from any of the medications I take.

E. DRUG SCREENING: I will participate in drug screening as part of my treatment plan. I agree to have them done on the day my physician requests it. Screening may include urinalysis, blood testing or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of services.

F. ILLEGAL AND NON-PRESCRIBED DRUG USE: It is a felony to obtain narcotic medications under false pretenses. I authorize the practice to cooperate fully with any city, state, or federal law enforcement agency, including this states Board of Pharmacy, in the investigations of any possible misuse, sale or other diversion of controlled medications. I authorize the practice to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance, including marijuana, may result in termination of care.

G. LOST OR STOLEN MEDICATIONS: **I agree to safeguard all medications prescribed by the undersigned physician and understand that medications will not be replaced if they are lost, get wet, are destroyed or damaged, left in an airplane, etc.** If my medication has been stolen, I will complete a police report regarding the theft, an exception may then be made.

H. PRESCRIPTIONS WHILE TRAVELING: The practice may provide prescriptions for up to 90 days when patients are traveling out of state. This will not be one 90 day prescription, but instead, 3 consecutive 30 day prescriptions with corresponding fill dates. Patients will have to arrange for shipment of controlled substances by their pharmacy at their own expense. Patients who will be out of the state longer than 90 days will need to arrange for health care at their travel destinations.

I. DRIVING & OPERATING EQUIPMENTS: Many medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and/or whenever I may feel drowsy.

J. TERMINATION: I will no longer be eligible for care if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or if arrested for DUI. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for care.

I, _____, have read the narcotic agreement and without question understand all of this agreement. All of my questions about the terms of this agreement have been answered to my satisfaction. ***By signing this agreement, I affirm that I have read, understand and accept all of the terms of this agreement.***

Patient Signature: _____ Nurse Signature: _____

Date: _____ Physician Signature: _____

_____ (Initial that you have received a copy of this contract - **Patient**)