TriValley Primary Care

CONTROLLED SUBSTANCES MANAGEMENT AGREEMENT

I, _____ understand that in order to receive controlled medications from TriValley Primary Care, I must and do agree to, and will comply with, the following:

A. MENTAL HEALTH: 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 health care providers of TriValley Primary Care.

B. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with a provider of TriValley Primary Care before making any changes in either the dose or frequency of my medications. There will be no early refills of controlled substances without prior authorization. Controlled substances must all be obtained from the same pharmacy (any exception must be approved by TriValley Primary Care). Controlled substance prescriptions will not be refilled on weekends or holidays.

C. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medications from any other health care provider unless authorized by TriValley Primary Care.

D. MEDICAL RECORDS RELEASES: I will inform all of my health care providers that I receive controlled substances through TriValley Primary Care and will maintain an unrestricted and current medical records release on file with TriValley Primary Care.

E. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use of any controlled medication not prescribed by TriValley Primary Care may result in termination of care. I authorize TriValley Primary Care to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled substances. I authorize TriValley Primary Care 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, will result in termination of care by TriValley Primary Care.

F. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by TriValley Primary Care and understand that lost or damaged medications will not be replaced.

G. DRUG SCREEN: I agree to provide a urine specimen for the purpose of a drug screen to my TriValley office at their discretion.

H. EVALUATION: I will see my prescribing physician at least every 6 months to evaluate my condition and my general state of health.

I. DRIVING & OPERATING EQUIPMENT: Many controlled substances 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 or whenever I feel drowsy.

J. TERMINATION: I will no longer be eligible for care at TriValley Primary Care if I am in possession of or using illicit drugs or substances, trafficking in controlled or illegal substances, intoxicated, arrested for DUI or if I am not using the medications as prescribed. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for care at TriValley Primary Care. Furthermore, violation of any of the terms of the above paragraphs can be sufficient reason for dismissal from TriValley Primary Care.

I have answered the following questions by checking the appropriate box and further writing as needed:

Have you ever had any medical or legal problems with alcoholism, drug abuse (including marijuana), addiction or drug trafficking? ☐ No ☐ Yes (if yes, explain)

_____

Have you used any illegal drugs (including marijuana) within the past six months? ☐ No ☐ Yes (if yes, list the drugs you have used and when)

_____

Have you used any prescription drugs for which you did not have a personal prescription with the past six months? ☐ No ☐ Yes (if yes, list the drugs you have used and when)

_____

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE AND DISMISSAL FROM TRIVALLEY PRIMARY CARE.

_____

Patient signature (SEAL) and date

_____

Provider signature and date

Print Form