Medication Agreement for Long Term Controlled Substance Prescriptions

This is an agreement between _____ and _____.
I am being treated with controlled substance medication for _____,
which I understand may be abused or cause addiction and is only one part of the treatment. I understand that, because this medication has risks and side effects, my clinician needs to monitor my treatment closely in order to keep him/her safe. I acknowledge my treatment plan may change over time to meet my goals, and that my clinician will discuss the risks of my medicine, the dose, and frequency of the medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

Parent Initials	**Please read the statements below and initial in the box at the left.**
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my goals.
	To reduce risk, I will take the medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my clinician of all side effects I experience.
	To reduce risk, I will not take narcotics, sedatives, alcohol, marijuana/cannabinoid products or illegal drugs while taking this medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I will bring my pill bottles with any remaining pills of this medicine for a pill count when requested by Mountain View Family Practice.
	I understand that my clinician or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my prescription for this medication only from Mountain View Family Practice clinicians. Refills will be made only during regular office hours. No refills will be provided on nights, holidays or weekends.
	I will fill my prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my medication in a safe place. I understand if my medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all of my scheduled follow-up appointments (at least every 3 months unless otherwise specified). I understand that I may not receive a prescription refill if I miss my appointment.

Medication name, dose, frequency:

_____

Pharmacy name/location:

_____

By signing below, we agree that we are comfortable with this agreement and our responsibilities:
Patient: _____ Date: _____
Physician/NP: _____ Date: _____