Controlled Substance Agreement

By initialling and affirming below, I agree to the following conditions as part of my ongoing pain management care:

_____ I understand that these medications carry a high risk of dependence, addiction, and potential side effects which my provider has discussed with me. My provider may stop providing these prescriptions if I break the terms of this agreement or if they find that the medicine is hurting more than helping me

_____ I will only take my medication as prescribed. I will not sell, trade, or share these medications. I will store these medications in a safe place. If these medications are stolen, I will file a police report. My provider will only refill the medication after seeing a police report.

_____ My provider will not refill this medication early if I lose my medications or prescriptions

_____ I will not get medicines or prescriptions for similar medications or other addictive medications from any other provider without notifying my pain management provider. The only exception is if I need a medication for an emergency at night or on the weekend. If this occurs, I will notify my provider.

_____ I will notify my provider about all medications I take, as well as street drugs and alcohol use.

_____ I understand that I will need to regularly comply with random urine and/or blood drug screens. If there are discrepancies between my prescribed medications and drug screens or if there is evidence of illicit substance use (e.g. heroin, cocaine, methamphetamines, LSD, PCP), my provider may decide to terminate the prescribing of controlled substances

_____ I am responsible to make sure I do not run out of medications on holidays or weekends. Refills will only be obtained during office hours.

_____ I will schedule and keep regular appointments for follow-up with my provider. If I have trouble keeping my appointments, I will tell my provider immediately.

_____ I will participate in other treatments and referrals that I am asked to do for my condition.

_____ I will sign a release to allow my provider to speak to all other providers I see and to see my prescription records

_____ I will treat the provider and staff with respect and not be disruptive at the office. Behavioral disturbances may result in termination of controlled substance prescription and/or discharge from my clinic.

Advanced Pain and Spine Institute of Florida

My provider and team agree to the following:

- We are committed to helping you get better and treating you in the safest way possible.
- We will help you set and reach goals for your treatment
- We will connect you with other forms of treatment to help you with your condition.
- If you become dependent or addicted to these medications, we will help you get treatment.
- Should you break the terms of this agreement, we will continue to treat your painful conditions in the appropriate fashion without the use of these controlled substances

Patient (print): _____

Signature:_____

Date:_____Time:_____

Provider (print): _____

Signature:_____

Date:_____Time:_____