Healthy Habits
wellness center

CONTRACT FOR CONTROLLED SUBSTANCE MEDICATIONS

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful, but they have a high potential for misuse and are, therefore, closely controlled by the local, state and federal government. They are intended to relieve pain, thus improving function and/or ability to work, not simply to "feel good." Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced or stolen, or if I "use it up" sooner than prescribed, I understand that it **will not be replaced regardless** of the circumstances.
2. I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from Dr. Jon Miller, Michele Fields, APRN, FNP-BC, Amber Ellis, APRN, FNP-BC, and/or Dena Barker, APRN, FNP-C.
3. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in the hospital.
4. Refills of controlled substances medications:
   a. Will be made only during regular office hours, in person. Our office hours for refills are Mondays and Wednesdays, 9:00 am to 3:00 pm, and Tuesdays and Thursdays, 9:00 am to 6:00 pm. In order to receive my refills, I must be seen every three months for scheduled office visits. Refills will not be made at night, on Fridays, weekends or holidays. Please note it may take 24-48 hours for prescriptions to be sent to the pharmacy.
   b. Will not be made if "I lost my prescription", "ran out early", or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the amount remaining.
   c. Will not be made as an "emergency", such as on Friday because "I suddenly realize I will run out tomorrow." I understand that I must call ahead at least twenty four (24) business hours if I need assistance with a controlled substance medication prescription.
5. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with Dr. Miller, Michele Fields, Amber Ellis and Dena Barker may be terminated immediately. If the violation involves obtaining these controlled substance medications from another individual, as described above, I may also be reported to other physicians, medical facilities, and the appropriate authorities.
6. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercise, weight control, and the avoidance of the use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome of my treatment. I must also comply with the treatment plan as prescribed by my physician.
7. I understand that I am subject to RANDOM DRUG screens at my healthcare provider's discretion.
8. I understand that West Virginia Board of Pharmacy inquiries may be performed and if it is noted that controlled substances are being obtained outside of this practice, I may be dismissed immediately from this practice.
9. I further understand, accept and agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

09/16

CONTRACT FOR CONTROLLED SUBSTANCE MEDICATIONS AUTHORIZATION

_____I have been fully informed by the providers and/or staff of Healthy Habits Wellness Center of the dangers of psychological dependence (addiction) of a controlled substance, which I understand, is rare. I know that some patients may develop a tolerance, which results in the need to increase the dose of the medication to achieve the same effect of pain control. I also am aware they I may become physically dependent on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

_____ I have read and been provided a copy of the Healthy Habits Wellness Center Contract for Controlled Substance Medications (08/14). The providers and/or staff of Healthy Habits Wellness Center have fully explained this policy to me and have answered any questions or concerns regarding this policy. In addition, I fully understand the consequences of violation of this contract.

_____I fully understand the consequences of violation of the Healthy Habits Wellness Center Contract for Controlled Substance Medications. I fully understand that if I am in violation of this agreement, my controlled substance prescriptions and/or treatment may be terminated immediately as well as permanent dismissal from Healthy Habits Wellness Center.

Patient Signature/Date of Birth	Date
Witness	Date