Lakeside Primary Care

Controlled Substance Agreement

You must agree to each of the following statements before Dr. Harrison will prescribe a ***controlled*** medication to you:

- I will take all medications exactly as instructed by Dr. Harrison. I understand that I will not receive early refills under any circumstance. If my pain control is inadequate, I will schedule an appointment to discuss this with Dr. Harrison. ***Any unauthorized increase in the dose of narcotic medication(s) may be viewed as a cause for discontinuation of the treatment with controlled medication(s)***.
- I recognize continued refills of controlled substance medications are contingent upon compliance with other treatments recommended by Dr. Harrison.
- I am responsible for my medications: If the prescription or medication is lost, misplaced, destroyed or if I run out of the medication before time for a refill, I understand that it will NOT be replaced. If my medication is stolen, I understand Dr. Harrison will not consider granting an early refill unless I provide him with a copy of the police report regarding the theft.
- I will arrange for refills at the prescribed intervals **during regular office hours only**. I am responsible for making sure I do not run out of my medications on weekends or holidays. I will not ask for refills earlier than agreed, after hours, on holidays or weekends.
- I will not request any pain medications or controlled substances from other providers and will inform Dr. Harrison of all other medications I am taking.
- I will inform my other health care providers that I am taking these controlled medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
- I understand that Lakeside Primary may communicate with physicians, pharmacists, insurance companies or any other entity or person regarding my use of controlled substances including, but not limited to, any prescription records accessed through the Prescription Monitoring Program in accordance with 18 VAC 76-20-70.

I agree to use only the pharmacy indicated below to fill ***controlled*** substance prescriptions:

______________________	______________________	______________________
Pharmacy	Location	Phone Number

I understand if I violate any of the above terms, or if Dr. Harrison believes I am not complying with this contract's terms, or believes I have lied about my compliance with this contract's terms, he will no longer fill my prescription and may require that I obtain help to decrease my use of these medications.

______________________________________ ______________________

Patient's Signature *Date*