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 ONLY during regular office hours. 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 hereby give Lakeside Primary Care permission to communicate with referring physicians, pharmacists, insurance companies or any other entity or person regarding my use of controlled substances.

I agree to use only the pharmacy indicated below to fill my prescriptions:

Pharmacy	Location	Phone Number

I understand if I violate any of the above terms, Dr. Harrison may choose to no longer fill my prescription or may require that I obtain help to decrease my use of these medications. In fact, 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 may choose to terminate my status as a patient with Lakeside Primary Care.

Patient's Signature *Date*

Witness