Ace Health and Wellness Center
14815 N Del Webb Blvd, Sun City, AZ 85351
Ph.(623) 248-1717 | Fax.(623) 248-1688
www.acehealthclinic.com

CONTROLLED SUBSTANCE AGREEMENT

Patient Name:_____ **DOB:**_____/_____/_____

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for _____ (print names of conditions- e.g., pain, anxiety, etc.).

The goals of this medication(s):

- ☐ To improve my ability to work and function at home.
- ☐ To help my _____ (print name of condition-e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following

_____ I am responsible for my medicines, I will not share, sell, or trade my medicine. I will not take anyone's medicine.

_____ I will not increase my medicine until I speak with my doctor or nurse.

_____ My Medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.

_____ I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)

_____ I will avoid withdrawal symptoms by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that "running out" of medication is not grounds for insisting on an "emergency or urgent appointment".

_____ I agree to give a blood or urine sample, if asked, to test for drug use.

_____ I will not combine this medication with other medications that can affect my mental acuity such as muscle relaxers and benzodiazepines.

_____ I will NOT use this medication with alcohol.

_____ I will NOT use this medication and operate any heavy machinery.

_____ I will NOT perform any task that requires a high degree of mental activity acuity that could result in my or someone else's harm or death.

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Refills:

Refills will be made only during regular office hours- Monday through Thursday, 8:00am - 5:00pm and Friday 8:00am- 2:00pm. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I must keep track of my medications. No early or emergency refills may be made.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor, and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working, I agree to provide primacy care for you even if you are no longer getting controlled medicines from me.

Patient signature:_____ **Date:** _____/_____/_____

Section Below to be completed by the physician only:

Physician Signature:_____ **Date:**_____/_____/_____

Patient agrees to come in every (circle one:) 30 Days 60 days