NEUROLOGY AND SPINE CENTER

Thomas C. Morell, M.D.

Controlled Substance and Pain Management Agreement

I, ______________________________ (the patient) agree to the following items as outlined by Dr. Thomas C. Morell, M.D. (Responsible Physician) in an effort to promote understanding and for compliance with state regulations.

I understand I have the right to comprehensive pain management. This may include being prescribed controlled substances. This agreement is essential to the trust and confidence necessary in a doctor/patient relationship in treating my pain.

I understand that failure to comply with any of these agreed statements may result in the discontinuation of my drug therapy and my discharge from the care of Dr. Morell.

I agree to the following statements:

1. I understand that I must keep my medications in a safe place.
2. I will not share or give my prescriptions to anyone else.
3. I will not accept any controlled substance prescriptions from another doctor or accept any controlled substances from any other source.
4. I agree to refrain from using any street drugs or abuse alcohol while under treatment.
5. I agree to take my prescribed medications at the dose and frequency as prescribed by my Doctor. I agree not to change the dosage or frequency of my medications without first consulting my Doctor.
6. I will be responsible for making sure that I do not run out of my medications and I am aware of Dr. Morell's prescription refill policy.
7. I understand there are risks as well as benefits associated with the use of controlled substances, including the risk of abuse/addiction as well as physical dependence and its consequences. I give my informed consent and agree to treatment with controlled substances.
8. Some drugs may have a potential for drowsiness and I agree to refrain from operating a motor vehicle or heavy equipment until drowsiness disappears.
9. I understand that abrupt discontinuation of certain controlled medications may cause severe withdrawal symptoms.

10. I understand that it will be necessary for me to submit to a urine drug screen (UDS) prior to my receiving any controlled substances. I further understand that it will be necessary for random UDS testing to be done periodically throughout the year as requested by my Doctor.
11. I understand that refills for some controlled substances will only be made at the time of an office visit with my Doctor and some prescriptions may only be written for a 30 day period. It is my responsibility to arrange my appointments to accommodate this.
12. I understand that while I am on a controlled substance, I must come in to see my Doctor a minimum of every three months.
13. If I lose my medicine or my prescription, I understand that I must contact my Doctor, file a police report and obtain a copy of that report for my Doctor.
14. If I do not fill a written prescription I am responsible for returning the original prescription to the office for appropriate destruction
15. I certify that if I am a female patient who becomes pregnant, decides to become pregnant or am nursing, I will report this immediately to my Doctor as there are special risks associated with taking these medications under these conditions.
16. I agree to use only one pharmacy for the filling of my controlled substance medications and to provide this information to my Doctor. I agree to allow my doctor to check my medications from all prescribing doctors verbally or electronically to coordinate my care.

    Pharmacy Name: ____
    Address: ____
    Phone Number: ____

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on _________ day of __________, 20___.

Patient Signature: ____

Physician Signature: ____

Witness: ____

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Dr. Thomas C. Morell, M.D.

08/2017