MAX HEALTH MAINE FAMILY PRACTICE

CONTROLLED SUBSTANCE CONTRACT

Controlled substances, including narcotic pain medication, are often used in the treatment of acute pain due to trauma or surgery and less commonly for chronic pain due to cancer, or less commonly non-cancer origins. These drugs have potential for addiction and inappropriate non-medical/illegal use. It is critical that these substances be prescribed and *used appropriately.* This contract is intended to clarify the relationship between prescribing physician and the patient for whom these substances are prescribed.

CONTRACT: I, _____ **agree to** the following provisions

as requirements for the receipt of controlled substances from Dr. T. A. Scriven:

A. I agree and commit to having Dr. Scriven be my ***only*** source of controlled substances (Narcotics, Benzodiazepines, etc). I will not/do not purchase them from any other source.

B. I agree that _____**(name of Pharmacy**) is the single pharmacy where I will obtain my controlled substances and medication.

C. I hereby provide written consent to other providers, emergency departments and pharmacies to report violations of the contract back to Dr. Scriven or her staff.

D. I understand that if my doctor becomes concerned that there has been illegal activity concerning controlled substances that the doctor will notify the proper authorities. Also, that my doctor or office may request pill counts at any time, along with drug screens in office at random times.

E. I understand that a violation of this contract will result in tapering and/or discontinuation of the narcotic prescription and/or benzodiazepines.

F. I understand that it is my responsibility to be guarded and discrete about possession narcotic medication(s), and that I must keep them in a secure place so that they may not be stolen. If my medication or prescriptions are lost or stolen, I understand that they must not be refilled, or refilled early. There are no early refills.

G. I agree to provide random urine in office samples at any time

(Patient signature)

SIGNED: _____ print name _____Date _____

SIGNED: _____ print name _____Date _____

Provider :