LAFENE HEALTH CENTER CONTROLLED MEDICATION AGREEMENT

The purpose of this contract is to help prevent misunderstandings about certain government-controlled medications that you will be taking. This will help you and your health care provider comply with state and federal laws regarding controlled medications.

- I understand that all prescriptions for controlled medications must come from the provider whose signature is below or, during his/her absence, by the covering provider, unless specific authorization is obtained for an exception.
- I will not attempt to obtain any controlled medicines, including opiate pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider. In the event that I develop a serious acute medical condition that another health care provider, such as an Emergency Department provider, determines an adjustment to my controlled medication use is in order, I will notify my LHC provider immediately of any changes.
- I understand that all controlled medications must be obtained at the same pharmacy, whenever possible. Should the need arise to change pharmacies, LHC must be informed. The pharmacy I have chosen is: ________________________________.
- I will only request renewals of my controlled medications during weekday business hours, 8:00 AM – 5:00 PM. Requests for renewals at other times will not be granted.
- I will give Lafene Health Center at least 72 hours (3 business days) notice for medication refills. If I do not give this notice, I understand that my prescription renewal will be delayed.
- Early renewals will not be given. Renewals will be based on my keeping scheduled appointments at a frequency determined by my provider.
- I will not consume excess amounts of alcohol, nor will I use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell or trade my medication with anyone.
- I will not adjust the dose or amount of controlled medications I take without first discussing and obtaining approval from my health care provider.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will safeguard my medicine from loss or theft. Lost, damaged, or stolen prescriptions or medicines will not be replaced.
- I agree that I will submit to an unannounced blood or urine test periodically as requested by my health care provider to determine my compliance with my program of controlled medicine use. Abnormal test results would be grounds for discontinuation of the prescribed medication. Refusal of such testing may also subject me to an immediate tapering/discontinuation of my medication.
- The LHC provider prescribing my medication has permission to discuss all diagnostic and treatment details with dispensing pharmacists and/or other professionals providing my health care, for the purpose of maintaining accountability.
• I understand that my LHC provider and my pharmacy will cooperate fully with any city, state or federal law enforcement agency, including the State of Kansas Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize LHC to provide a copy of the Agreement to my pharmacy, other health care providers, emergency departments, and insurance carriers, as necessary. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the authorizations.

• I understand that if I break this agreement, my LHC health care provider will stop prescribing these controlled medicines for me until compliance with this agreement is re-established.

• A Lafene Health Center provider may reserve the right to stop prescribing your controlled medications at his/her discretion, and in this case no other Lafene provider will assume care that involves prescribing controlled medications.

• I have thoroughly read this agreement and any questions that I have concerning the agreement, have been answered to my satisfaction by my LHC provider.

______________________________  ______________________
Patient Name (Print)  WID#

______________________________  ______________________
Patient Signature  Date

______________________________  ______________________
Provider Name (Print)

______________________________  ______________________
Provider Signature  Date