Florida Medical Clinic
Your Life. Our Specialty
38135 Market Square
Zephyrhills, FL 33542

Florida Medical Clinic, LLC
Patient Responsibility and Controlled Substance Agreement

Between Patient: _____ and Provider: _____

The Florida Legislature has laws governing the prescription of controlled drugs. A drug is classified as a controlled substance based on the relative abuse potential of the drug and the likelihood of its causing dependence. Controlled substance medications (ie, narcotics, benzodiazepines, sleep aids, stimulants and barbiturates) are very useful but have a high potential for misuse and are therefore, closely controlled by local, state, and federal governments. They are intended to relieve **pain, psychoactive disorders**, and other medical conditions, thus improving functions and/or ability to work.

The controlled substance my Provider is prescribing is: _____.
To comply with these laws, I acknowledge and agree to the following:

1. I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances. I understand that the long-term advantages and disadvantages of chronic use have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with long-term use of controlled substances and that my Provider will advise me of any advances in this field and will make treatment changes as needed.
2. I agree that only my provider will prescribe controlled substance medication. I will not obtain or use any controlled substance from a source other than my provider. I will instruct my other providers to confer with my provider for any changes or need for additional controlled substance medication. If it is discovered that the other providers are prescribing medications for me, my provider reserves the right to discontinue prescribing medications and/or discharge me from the clinic. I understand that my provider **will be** verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Drug Monitoring Program website periodically throughout my treatment period.
3. **At the Providers discretion** refills can be written or sent electronically. Prescriptions for most controlled substance medications can only be written for a 30 day supply. If written, I understand I will need to come in and pick up the prescription. **I or authorized persons must provide proof of identity to pick up my prescription for controlled substance.**
4. All medicine should be filled at the same pharmacy, when possible. The pharmacy I have selected is (Name/Phone):

   _____

5. I must be seen by my provider **every ___ month(s)** to continue to get refills. Routine blood work and random urine drug screens may be part of my treatment plan. I agree to have them done on the day my provider requests it.
6. ◯ **Option 1:** My provider's office requires a 72 hour notice to refill prescriptions. Prescriptions can only be refilled during normal business hours. They will NOT be refilled at night or on weekends.

   ◯ **Option 2: Prescriptions can only be refilled during scheduled appointments.** They will NOT be refilled in between appointments, at night or on weekends.

   (The selected option will be at the Provider's discretion and based on the drug class and/or scheduled control substance)
7. My provider's office is not responsible for any controlled substance medications that have been misplaced, lost or stolen. Controlled substances cannot be refilled before the renewal date.
8. I agree that I will use my medication at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time and may result in termination from the practice.
9. In the case where my provider feels it is time to stop the medicine; my provider will help me do it safely by giving me clear instructions on how to taper the medication(s) safely and will be available to help me at any time during the tapering process. My Provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. It may be deemed necessary by my Provider that I see a medication use specialist at any time while I am receiving controlled substance medication(s). I understand that if I do not attend such an appointment, my medication(s) may be discontinued or may not be refilled beyond a tapering dose to completion. Also, a drug-dependence treatment program may be recommended. I would also be amendable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary. I understand that if the Provider feels that I am at risk for psychological dependence (addiction), my medication(s) will no longer be refilled.
10. **I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.**
11. I understand that the main treatment goal is to reduce symptoms and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits: exercise, weight control and avoidance of the use of tobacco and alcohol. I understand that a successful outcome of my treatment will only be achieved by following a healthy lifestyle.

12. It is a crime to obtain controlled substances under false pretenses. This could include getting medications from more than one provider, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). If my Provider has reason to believe that I have violated this agreement, the provider has the right to notify and cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I understand all confidentiality is waived and these authorities may be given full access to my records.
13. I authorize my Provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room.
14. My provider has the right to discontinue controlled substance medications and discharge me from care if any of the following occur:
    - I trade, sell, misuse or share medication with others;
    - The clinic discovers I have broken any part of this agreement;
    - I do not go for blood work or urine tests when asked;
    - My blood or urine shows the presence of medications that my provider is not aware of, the presence of illegal drugs or does not show medications that I am receiving a prescription for;
    - I get controlled substances from sources other than Florida Medical Clinic Providers;
    - I exhibit any aggressive behavior toward the providers and/or staff;
    - I consistently miss appointments.
15. At the request of my Provider, I will bring any unused controlled substance medicine to every office visit. I will communicate fully with my provider about the character and intensity of my condition, on the day to day functioning, and how well the medicine is controlling symptoms.
16. **I have read this agreement in its entirety and agree to follow these guidelines that have been fully explained to me by _____ (Provider). In addition, I fully understand the consequences of violating this agreement.**

I have been fully informed by my Provider and office staff regarding psychological dependence (addiction) of controlled substance medications, which I understand is rare. I know that some individuals may develop a tolerance to the medications necessitating a dose increase to achieve the desired effect and that this is a risk of becoming physically dependent on the medication. This will occur if I am on the medication for several weeks; therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I hold Florida Medical Clinic Providers harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

_____	_____
Patient/Guardian Signature	Date
_____	_____
Printed Patient's Name	Date of Birth
_____	_____
Witness Signature & Date	Provider Signature & Date
_____	_____
Printed Witness's Name	Printed Provider's Name