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□ Bernedette Minnella, MD
□ George B. Plain, MD
□ Catherine Tan, MD
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300 White Spruce Blvd
Suite 100
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Patient Name: DOB: Account #:

CONTROLLED SUBSTANCE USE AGREEMENT

The Practices of Drs. Cahn-Hidalgo, Minnella, Plain, Tan and Yoon are committed to doing what we can to treat chronic pain and other conditions. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and other conditions. Controlled substances are strictly regulated by both state and federal agencies. This agreement is to assist you to understand the guidelines for proper controlled substance use.

I, _____, am requesting treatment for my pain or condition that requires the use of a controlled substance. As a condition of my treatment, I accept the following:

1. I have been informed of the risks and the benefits of the use of controlled substances, including the risk of tolerance and drug dependency.
2. I will be responsible for calling the office during regular office hours or sending a portal message for my medication refills at least 2-3 days but not more than 7 days before the end of my medication. I will make sure to pay attention for nights, weekends and holidays. Controlled substances will not be prescribed after hours, on weekends or during holidays. I understand that abrupt discontinuation of these medications will cause severe withdrawal syndrome, such as nausea, vomiting, diarrhea, aches, sweats, chills that may occur within 24-48 hours of the last dose.
3. I understand my prescriptions will be eprescribed to my chosen pharmacy.
4. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
5. I understand that all controlled substances must be prescribed by the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. I will not obtain controlled substances from any other physician. Early refills will not be given. Renewals are based on kept appointments.
6. All Controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that I have selected is:

Pharmacy:

Phone: Location:

7. I give my prescribing physician permission to discuss all diagnostic and treatment details with my dispensing pharmacist or other professionals who provide my health care for purpose of maintaining accountability.
8. I, and I alone, am responsible for the protection of my medications and to keep them in my possession at all times. If I lose them, for whatever reason, I will not ask for an early refill or for prescriptions to be called in.
9. I will not participate in the diversion of my medications for illegal use; nor will I give or sell them to anyone else.
10. I will not seek the same or similar medications from any other source, whether professional or otherwise, and if I am prescribed them by another practitioner, I will notify the physician here.
11. I will take the medication as prescribed. I will not take extra doses without first discussing it with my physician.
12. I understand that if I am pregnant or become pregnant while taking opoid medication that my child would be physically dependent on the opioid medication and withdrawal can be life-threatening for a baby.
13. I will not consume alcohol or take other mood altering drugs while taking this medication.
14. I will disclose to my physician all drugs I take at any time, prescribed by any physician. I will keep an accurate list of medications with me at all times.
15. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications.
16. I understand that I will undergo medical tests and examinations before and during my treatment. These tests include random unannounced checks for drugs and alcohol and I hereby give my permission to perform the tests or my refusal may lead to termination of treatment with the physician. Presence of unauthorized substances may result in discharge from the practice.
17. I understand I may be discharged, in accordance with practice standards, from treatment for violation of this Agreement.

Patient Signature Date

Physician Signature Date