DOCTOR DOUG

'The secret in the care of the patient is in caring for the patient'

Patient Contract for Controlled Substances

Date: _____

Name: _____ Date of Birth: _____

This is the Agreement between _____, and Douglas M. Lakin, MD, Paradise Valley Medical Clinic, for treatment of chronic condition with controlled substances.

_____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 this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes to treat me based on this Agreement.

_____I understand that if I break this Agreement, Douglas M. Lakin, MD will stop prescribing these controlled medications.

_____In this case, Douglas M. Lakin, MD will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____I understand that Douglas M. Lakin, MD will be the **ONLY** provider writing prescriptions for my controlled substances. I agree **NOT** to obtain any controlled substances from any other provider.

_____I understand I will see Douglas M. Lakin, MD on a three-month basis to review my plan of care for my condition. I will keep all scheduled appointments with Douglas M. Lakin, MD unless I give a cancellation 24 hours in advance.

_____I understand I will NOT go to the emergency room for control substances for my chronic conditions, for which Douglas M. Lakin, MD currently treating me.

_____I understand **NO** controlled substances will be prescribed **AFTER** business hours, weekends, holidays, or emails.

_____I understand all controlled substance prescription will be prescribed only during business hours Monday – Thursday 8:00 – 4:00pm. No control substance prescriptions will be written on Fridays. It will be the patient's responsibility to keep track of medications in order not to run out of medications.

_____I understand NO controlled medications will be written when Douglas M. Lakin, MD is out of the office.

_____I understand if my controlled substance medication is lost or stolen it will not be replaced. It is my responsibility to ensure that prescriptions are filled correctly at the pharmacy and kept in a safe location. If I realize my medication has been lost/stolen, a police report must be filed and the police report with the case number must be submitted to Douglas M. Lakin, MD for possible consideration of a refill of the prescription**. ONE TIME ONLY.**

_____I Agree to use **ONLY** one pharmacy: _____, located at:_____, with the telephone number of _____, for filling my prescriptions for all my controlled medicine. **If I change pharmacies, I need to notify PVMC directly!**

_____I understand and will Agee to a random drug-screening test when Douglas M. Lakin, MD requests the collection. The test can be done by urine and/or blood to complete the screening at Douglas M. Lakin, MD's discretion.

_____I will not share my medication with anyone.

_____I authorized Douglas M. Lakin, MD and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State of Arizona Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize Douglas M. Lakin, MD to provide a copy of the Agreement to my pharmacy, other primary providers, and local emergency room. I agree to waive my applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____I give permission and understand that Douglas M. Lakin, MD will be verifying that I am receiving controlled substances from one provider and one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____I will bring unused medications to every office visit.

_____I agree to follow these guidelines that have been fully explained to me.

All 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 this _____day of _____, _____

Patient Signature: _____

Patient Name (Print)_____

Provider Signature: _____
Douglas M. Lakin, MD

Witness by: _____

Name (Printed)_____