



*Prevention & Medical Care
To Help You Live Better, Longer.*

Agreement and Informed Consent for Controlled Substance Therapy

This treatment agreement describes the agreement that I have with my Primary Care Provider (PCP) about controlled substance therapy. This agreement covers any long term treatment I use that involves opioids (narcotic pain medicine), sedatives, tranquilizers, skin patches, or benzodiazepams.

1. My PCP and office staff are committed to treating me as a person entitled to dignified and sensitive care for a serious medical condition.
2. I have been told that this agreement is needed because controlled substances can be **risky and even fatal**, unless I use them only as my PCP had ordered.
3. **I know that if I do not comply with this agreement, my PCP may end my controlled substances therapy for my own well-being.**
4. My PCP has explained the therapy to me, including the likely benefits and risks, side effects and other potential problems with the therapy.
5. My PCP expects that I will have reduced pain and a better quality of life as a result of the therapy. Complete pain relief is not likely. I also know that my PCP may suggest additional therapies, such as counseling, physical therapy, yoga, acupuncture and regular exercise. I agree to seriously consider these therapies to improve my health.
6. I understand there are risks and the potential for negative side effects of therapy involving controlled substances. These risks and side effects can include physical dependence and, in rare cases, addiction behavior. These medicines can sometimes mask other serious conditions. In some cases, long term use of pain medications can increase sensitivity to pain. They may cause nightmares, psychotic states, hallucinations, or depressed moods. Sleepiness or slowing of reflexes, especially at the beginning of therapy, may occur and make it unwise for me to drive. Nausea, itching, sweating, dry mouth, retained urine, constipation, low testosterone, depressed breathing and muscle jerking at night are other possible side effects.
7. I have been told that a quick decrease or stopping of the drugs may lead to symptoms of withdrawal. The symptoms include pain, nausea, diarrhea, anxiety,

sweating, and tremor seizures. I will inform my PCP if I choose to stop any of my medicines. My PCP may direct a slow taper to avoid the side effects.

8. I understand there are serious risks in mixing mind-altering drugs or substances when I am on controlled substance therapy. These include alcohol, narcotics, methadone, suboxone, sedatives, and sleeping pills. Taking other drugs or substances while on therapy could result in over-sedation and could lead to serious injury or death. I will not use any alcohol, sedating medicines or other prescribed narcotics during my course of therapy without the written permission of my PCP. I will not use any illegal drugs or substances.
9. If I take controlled substances while pregnant, my child may be born with a physical dependency on those substances or otherwise be physically harmed. I will immediately inform my PCP if I believe that I may be pregnant. I will inform any provider of prenatal care that I am taking controlled substance therapy.
10. I understand that, because of the potential risks and side effects of my therapy, as well as the potential benefits, it is important that my controlled substance therapy be closely and carefully managed. For safe and effective management of my care, I agree that my PCP may share the necessary information about my therapy with other healthcare providers. **I also agree to keep all follow up appointments every 3 months with my PCP and any referral appointments.**
11. I understand that the misuse or diversion of controlled substances create serious risk of harm to individuals and society. It is also illegal. Valley Medical Group closely manages controlled substance prescriptions. For that reason, during the course of my controlled substance therapy:
 - I will not attempt to get controlled substances from other healthcare providers. In case of an emergency, I shall tell the other healthcare provider that I am on a controlled substance therapy. I will also promptly notify my PCP if I have gotten controlled substances from another provider.
 - I will contact my PCP's office 48 hours before running out of my prescribed medicine or participate in the Controlled Substance Refill Program (CSRFP) as requested by my PCP.
 - I agree to random urine drug testing and random pill counts as directed by my PCP.
 - I agree that I will not seek early refills and that none will be provided. This includes medicine that has been stolen, misplaced, or lost.

