Palmetto Family Medicine
A Lexington Medical Center Physician Practice

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Lexington Medical Center

Prescription Contract

Bring this contract with you to your first appointment.

PATIENT:(PRINT)_____ DATE OF BIRTH: _____ DATE: _____

The conditions of this agreement follow nationally accepted standards of care for managing patients on chronic pain medications. Narcotics, pain medications, tranquilizers, barbiturates and sleeping pills are very useful but have a high potential for misuse. There is also a risk of developing an addiction or of a relapse occurring in a person with a prior addiction. Because these medicines have potential for abuse or diversion, strict accountability is necessary for prolonged use.
Local, state and federal governments, therefore, closely control them. They are intended to relieve pain or to improve function and/or ability to work. Such medications are not used to simply feel good. This is for your safety, protects your access to controlled substances, and protects your provider's ability to prescribe for you.

I, _____, agree to the following conditions because my physician is prescribing such medication for me to help manage my pain/anxiety/etc.

_____ 1. I understand that all controlled substances must be prescribed by the assigned provider or his/her selected representative at Palmetto Family Medicine.
My assigned provider is _____.

_____ 2. I will obtain all controlled substances from the same pharmacy. If I need to change pharmacies, I will notify this office.
The pharmacy I have selected is: _____Phone:_____.

_____ 3. I understand that it is my responsibility (as the patient) to make sure my pharmacy has my medicine in stock. Prescriptions will not be rewritten due to out of stock issues.

_____ 4. I will inform this office of any new medications I take or of any bad side effects I experience from my medication. I will also inform this office of any new medical condition I may develop.

_____ 5. I give my provider permission to discuss my diagnosis and treatment details with my pharmacists or other professionals who provide health care for purposes of maintaining accountability.

_____ 6. I will not share, sell, or permit others to have access to these medications.

_____ 7. I will inform other health care providers of my medications.

_____ 8. I will not increase my medication use, alter a prescription or change the prescribed schedule for taking my medication without the approval of my doctor.

_____ 9. I will not use any illegal drugs or obtain drugs illegally.

_____ 10. I understand that these medicines should not be stopped abruptly, as an abstinence syndrome will likely develop.

_____ 11. I agree to random blood screens and/ or random urine screens. If there are unauthorized substances, or if my prescribed medication is not present, I may be referred for assessment for addictive disorder and/ or I maybe discharged from this office.

_____ 12. I will keep my medicine and prescription safe as these medications may be sought by other people who have chemical dependency. I will not leave my prescription or medicine anywhere someone could take them. I will make sure to keep this medicine out of reach of pets, children, or anyone else, since these medicines may hurt or kill someone.

_____ 13. I will bring my original containers of medicine to each clinic visit and may be asked to come in to the office at times other than my scheduled appointments for a pill count.

_____ 14. I may receive medications from other health care providers while hospitalized or in the ER, but I will not accept the prescriptions for controlled medications upon discharge unless approved by my prescribing/pain clinic provider.

_____ 15. I understand that my medicines will not be replaced if they are lost, spilled, destroyed or misplaced. If my medicine is stolen a police report should be filed. Stolen drugs may or may not be refilled at the discretion of your provider.

_____ 16. I understand that early refills will not be given. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

_____ 17. I understand that refills will only be given during designated office hours MONDAY through THURSDAY (8 a.m. – 3 p.m.). Refills will not be made at night, on holidays or the weekends. Refills will not be made in "emergency situations" and should be called in at least 24 hours in advance. I must come to my office appointments in order to have my medicines continued. No refills or dose changes can be made after hours or on weekends. Appointments will be scheduled _____ (time frame), and failure to be compliant with this schedule (for example, repeated cancellations or rescheduling or arriving late) may result in my being discharged from this office.

_____ 18. I understand that if questions arise concerning my compliance with this agreement (for example, if I obtain my medicines from several different pharmacies), responsible legal authorities may be given full access to my records regarding controlled substances and confidentiality waived.

_____ 19. I understand that if I do not follow these policies, my doctor will not be able to prescribe these medicines for me, my doctor will discharge me from the clinic, and my doctor may not be able to refer me to another specialist.

_____ 20. I understand that any medication (as listed on 1st page) treatment is a trial and that it will only be continued if I benefit from it. The goals of treatment of pain with medications are to decrease pain, increase quality of life and increase level of function. If all of those criteria are not met, medications may need to be adjusted or discontinued. Elimination of pain, while an ideal endpoint, is often not a reasonable expectation.

_____ 21. I understand that other treatment options such non- opioid medication, injections, massage therapy, physical therapy, psychological therapy, or psychiatric therapy may be recommended by my provider and that I will comply with the full scope of multidisciplinary pain management as suggested.

_____ 22. My doctor has the right to discharge any patient with 30 days notice at any time.

_____ 23. I have received information from my provider on the risks and possible benefits from this medication treatment.

_____ 24. I have read and understand this agreement and had a chance to ask questions. I agree to follow this policy.

OFFICE SIGNATURE:_____ DATE: _____

PROVIDER SIGNATURE:_____ DATE: _____

PATIENT SIGNATURE:_____ DATE: _____