

LAKE INTERNAL MEDICINE ASSOCIATES
Steven M. Tang, M.D.
2101 Prevatt Street Eustis, Florida 32726

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. Opioids, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and are therefore closely controlled by the local, state and federal government. They are intended to **relieve** pain, to **improve** function and/or **ability** to work, **not** simply to feel good. Because my physician is prescribing such a medication for me to help manage my pain/medical condition, I agree to the following conditions:

1. **I am responsible for my controlled substance medications.** If the prescription of medication is lost, misplaced, stolen or if I use it up sooner than prescribed, I understand that **it will not be replaced.**
2. **I agree to keep all appointments with Dr. Tang.** Florida law requires that I be seen at least every 3 months. Dr. Tang may require me to be seen more frequently. I am aware I will not receive refills if I do not keep all appointments.
3. **I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from Dr. Tang while under his care.** Besides being illegal to do so, it may endanger my health. Exceptions must be authorized by Dr. Tang
4. **I agree to use the same pharmacy for all controlled substance prescriptions,** as much as possible. I will not routinely have controlled substance prescriptions filled at multiple pharmacies.
5. **Refills** of controlled substance medication:
 - a. **Will be made only during regular business hours,** once a month. Refills will not be made at night, on holidays or weekends.
 - b. **Will be for a one month supply,** usually.
 - c. **Will not be made** if I “run out early” or “lose a prescription” or “spill or misplace my medication”. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
 - d. **Will not be made** as an “emergency” such as a Friday afternoon when the office is closed because I suddenly realize I will “run out tomorrow”. I will call at least seventy-two (72) hours ahead for a refill of a controlled substance medication prescription.
 - e. **Will be** picked up by me, in person or by someone with written permission from me. This arrangement will be made in advance with the office.
6. It may be deemed necessary by Dr. Tang for me to see a board-certified pain management specialist, an addiction medicine specialist, or a mental health addiction facility at any time while I am receiving controlled substance medicines. I understand if I do not attend this appointment that my medications may not be continued or refilled beyond a tapering dose to completion. I understand that if this specialist feels I’m at risk for psychological dependence (addiction) that my medications will no longer be refilled and I will be referred for treatment.

7. **I agree to comply** with random urine, blood or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed at times while taking controlled substance medications and that it is my responsibility to comply with the laws of this state while taking the controlled substance medication prescribed.
8. I understand that **if I violate any of the above conditions,** my controlled substance prescriptions and/or treatment may be ended **immediately.** If the violation involves obtaining controlled substances from another individual, as described above, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to my physician, medical facilities and other appropriate authorities.
9. I understand that the **main treatment goal is to improve my ability to function and/or work and/or reduce pain.** In consideration of that goal and the fact that I am given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, avoiding the use of tobacco and alcohol. I must comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
10. I understand that the **long-term advantages of chronic opioid use have yet to be scientifically determined** and that treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substance medications. These medications should not be taken during pregnancy.

Pharmacy Chosen: _____

I have been fully informed by Dr. Tang regarding psychological dependence (addiction) of a controlled substance medication. I know that some persons may develop a tolerance, which is the need to increase the dose of medication to achieve the desired effect, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this agreement and the same has been explained to my by Dr. Tang. In addition, I fully understand the consequences of violating this agreement.

Patient's Signature

Date

Witness Signature

Date