ENCOMPASS
MEDICAL GROUP

Controlled Substance Maintenance Agreement

I understand that certain substances have the potential for misuse and are, therefore, closely controlled by Federal regulations. Because my physician is prescribing this type of medication, I agree to the following conditions:

I understand that I am responsible for my controlled medications.

- I understand and agree to take the medication only as prescribed.
- I agree to see only one physician in this office for my controlled medications and understand that other physicians in this practice will not prescribe controlled substances for me.
- I agree to use one pharmacy and will supply my doctor with the name and phone number of that pharmacy. I understand my doctor's office may contact the pharmacy, or other pharmacies if he/she desires information.
- I understand I will not be given early refills if my mediation "runs out early", is lost, dropped down the toilet or sink, eaten by pets, contaminated, or stolen.
- I agree that I will not give or sell my mediation to anyone else and I will not take any other controlled substance medications without the consent of my physician.

I understand that I will be given a one-month supply of medication.

- I agree and understand the importance of keeping my scheduled appointments and will get my prescriptions refilled at that time.
- If a change in my medication dosing is required, then I understand I must make an appointment to see my doctor about those changes.
- I also agree to keep my referral appointments (for example: physical therapy, mental health, specialists, pain management, x-ray (MRI, CT scans, etc).
- I understand that I can call with problems or refills during regular office hours only (Monday through Friday, 9 AM to 4 PM)
- I also agree not to use the Emergency Room solely to obtain additional medication.

I will also provide medical records from my other doctors as requested.

I give my permission to have a copy of this agreement sent to my pharmacy is needed.

I understand that if I do not follow these conditions, my physician my not refill my controlled substance medications and may discharge me from his/her care. If discharged, I understand I may not choose another Encompass Medical Group physician at this, or any other, location.

Patient Signature _____ Date _____

Physician Signature _____

Pharmacy Name _____ Phone Number _____