Controlled Substance Agreement

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Dr. S. Zalzala, Provincial Pharmacy and staff are committed to doing all we can to treat your health conditions. In some cases, controlled substances are used as a therapeutic option for many chronic disorders. Controlled Substances are regulated by various government agencies. This agreement is a tool to protect both you the patient and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained as an exception. I understand that I must tell this physician all drugs that I am taking, have purchased, or have obtained, including over-the-counter medications and supplements. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

2. All prescriptions for controlled substances will be sent directly to the on-site pharmacy, Provincial Pharmacy, unless prior arrangements are made and approved by the physician.

3. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed.

4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from my patient roster and this facility.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI (Driving Under the Influence) charges.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7. Early refills will not be given. Renewals are based upon taking your medications as prescribed and keeping scheduled appointments. Prescriptions will only be renewed in person and not by phone.

8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at this facility and that law enforcement officials may be contacted.

10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me or made available upon request.

_____	_____	_____
PATIENT'S FULL NAME	PATIENT'S SIGNATURE	DATE
_____		_____
PHYSICIAN'S SIGNATURE		DATE

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