

# Macomb Medical Clinic, P.C.

English Version:

Macomb Medical Clinic, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Spanish Version:

Macomb Medical Clinic, P.C. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

## CONTROLLED SUBSTANCE MEDICATION AGREEMENT

### \*READ CAREFULLY\*

I \_\_\_\_\_, D.O.B. \_\_\_\_\_ UNDERSTAND THAT THIS AGREEMENT AS SIGNED BY ME RELATES TO MY USE OF CONTROLLED SUBSTANCES AS PART OF THE TREATMENT PROGRAM FOR MY CHRONIC CONDITIONS IDENTIFIED BY ANY PHYSICIANS AT MACOMB MEDICAL CLINIC, P.C.

I UNDERSTAND THAT THE MEDICATIONS PROVIDED BY MY PHYSICIANS WILL BE PRESCRIBED ONLY IF I ADHERE TOTALLY TO THE FOLLOWING CONDITIONS:

- I will consume the medications **ONLY** as prescribed by the physicians.
- I acknowledge that **ALL** refills of controlled substances will be made only during regular office hours, in person, once a month and during a scheduled office visit. Refill will not be made at night or during the holidays. I will not ask or expect to receive additional medications for those that I have lost or have been "Stolen".
- I am aware and accept that random-unannounced-urine or blood screens will be performed to detect the medications prescribed as well as drugs not prescribed including those illicit.
- I will only accept controlled substance medications from physicians directly associated with Macomb Medical Clinic, P.C. I will not give or sell my medications to anyone else including family members. I agree to be responsible for the secure storage of my medications at all times. I understand that lost or sold medications will not be replaced. If your medications has been stolen you must complete a police report.
- If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of your controlled substance administrations.
- I am aware I **MUST** report to the physician at Macomb Medical Clinic, P.C. **ANY** medications I receive from any other physician including those obtained through an emergency room visit. If it is proven that I did obtain like or similar prescriptions from another provider following my acceptance of this agreement and did not inform my physician of that prescription, I understand that I will be formally and permanently **DISCHARGED FROM THE PRACTICE**. I AM AWARE THERE ARE **NO** second chances under these circumstances.
- I understand should a controlled substance, which should have been present in my specimen is not found, or a substance is found that should not have been present, that I am subject to **IMMEDIATE AND PERMANENT** discharge from the practice.
- I understand that, if my physician recommended additional therapy specific to physical and psychological and I fail to follow these recommendations, I am subject to **IMMEDIATE AND PERMANENT** discharge from the practice.
- I agree to fill all controlled substance prescriptions at one pharmacy only. That pharmacy is \_\_\_\_\_. I am aware that I should count all medications when I pick them up as errors are a matter between me and the pharmacy and not subject to physician involvement.
- I am aware that this contract becomes a part of my permanent record. My signature on this document attests to the fact that I understand and agree to its content and context in its entirety.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date