**R. Marcy Henson, DNP APRN FNP-C**
**Shay Hudson, MSN APRN FNP-C**
**April Morris, DNP, APRN AGPCNP-BC**
**Alie Dodson, MSN APRN FNP-C**
**Molly Springate, MS APRN FNP-C**

# CONTROLLED SUBSTANCE/NARCOTIC CONSENT

I, ______________________________ agree to use all controlled substances prescribed to me per the following criteria. I understand that these medications may not eliminate my pain or condition but may reduce it and improve what I am able to do each day. I understand the following guidelines for continuing treatment or conditions under the care of the providers of Family Focused Care.

I understand that I have the following responsibilities:

a. I will take medications at the dose and frequency prescribed. I will not increase or change how I take my medications without the approval of a health care provider from Family Focused Care.
b. I will arrange for refills at the prescribed interval ONLY during regular office hours.
c. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
d. I will not fill my medications out-of-state.
e. I will not ask the providers of Family Focused Care to post-date any prescription.
f. I will obtain all refills for these medications only at the pharmacy listed below.
g. I consent to my provider and pharmacist to exchange information in writing, verbally or by mail.
h. I will not request any pain medications or controlled substances from other providers not employed by Family Focused Care and will inform this provider of all other medications I am taking.
i. I will inform my other health care providers that I am taking these controlled medications and of the existence of this contract. In event of an emergency, I will provide this same information to emergency department providers.
j. I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
k. I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
l. I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider. I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities. I will see all specialists as advised by my provider.
m. I will not use illegal or street drugs or another person's prescription.
n. I will consent to random drug screenings to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking and that if I do not have insurance, I may be responsible for any bills associated with the above noted testing.
o. I will keep all of my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.
p. I understand that my provider may stop prescribing the medications listed if: I do not show any improvement, develop rapid tolerance or loss of improvement from the treatment, and develop significant side effects from the medication or if I am disrespectful to any staff member or provider of Family Focused Care.
q. I understand that Family Focused Care does not treat chronic pain conditions and/or will not refill pain medications.

If my behavior is inconsistent with the responsibilities outlined above, I may be prevented from receiving further care from this practice.

| ______________________________ | ______________________________ | ____________________ |
|---|---|---|
| Pharmacy | Address | Phone |
| ______________________________ | ______________________________ | ____________________ |
| Patient Signature | Date | Date of Birth |

## HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health InsurancePortability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _______________________________________ Date of Birth: ________________

I authorize Family Focused Care and Health Fusion of Texas to use or disclose the following health information (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_______________________________________________________________________________________

☐ - My health information covering the period from _____________ (date) to ______________ (date)

☐ - Other: ____________________________________________________________________________

The above party may disclose this health information to the following recipient(s):

| | Name | Relationship | Phone Number |
|---|---|---|---|
| 1. | _____________________________ | __________________________________ | ____________________ |
| 2. | _____________________________ | __________________________________ | ____________________ |
| 3. | _____________________________ | __________________________________ | ____________________ |

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revokethis authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannotbe taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization.

Patient Signature :_____________________________________________Date:______________

If the patient is a minor or unable to sign, please complete the following

☐ - Patient is a minor:__________________years of age

☐ - Patient is unable to sign because:_______________________________________________________

Signature of Authorized Representative: ______________________________ Date: ________________