FAMILY FOCUSED CARE
HEALTH FUSION OF TEXAS

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
_____	_____	_____
Patients Name	Date of Birth	Date