



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

My behavior is inconsistent with the responsibilities outlined above, which may also result in being prevented from receiving further care from this practice.

Pharmacy

Address

Phone #

Patient Signature

Date

Date of Birth