CONTROLLED SUBSTANCES AGREEMENT

I have been informed that individuals who are prescribed certain controlled substances including, but not limited to, opioid pain medicines, stimulants, benzodiazepines and barbiturates can abuse those substances or may allow abuse by others and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to manage my pain.

1. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense while pain medication is prescribed to me.

2. All pain medication must come from Dr. Barroga. My pain medication will come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific written authorization is obtained from the office for an exception.

3. I will inform the office of Dr. Barroga, of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

4. I will inform my other health care providers that I am taking pain medication and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

5. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.

6. I will not allow anyone else to have, use, sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is against the law.

7. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

8. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor’s written prescription.

9. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

10. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.

11. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by Dr. Barroga.

12. I understand that there is limited evidence as to the benefit of long term opioid therapy.

Initials: __________
13. I will cooperate with unannounced blood, urine, hair or saliva toxicology screenings as may be requested, as well as any random pill counts of medication by the office of Dr. Barroga.

14. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

15. I understand that medications may not be replaced if they are lost, damaged, or stolen.

16. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due.

17. If the responsible legal authorities have questions concerning my treatment, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

18. I understand that I may be asked to bring my medications in their original container to the office of Dr. Barroga, while I am on controlled medication.

19. Refills will not be given over the phone, after office hours, during the weekends, and on holidays.

20. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by my physician at the office of Dr. Barroga.

21. I have been explained the potential benefits of opioid therapy, including, but not limited to, realistic expectations for sustained pain relief and improved functioning and possibilities for lack of pain relief. I have also been explained the potential risks and side effects, including, but not limited to, psychological addiction, physical dependence, withdrawal, over dosage, tolerance, misuse, constipation, impairment of judgement, sedation, cognitive and/or motor impairment.

22. I understand that failure to adhere to these policies and/or failure to comply with physician’s treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.

23. In case of emergency, I will contact Dr. Barroga’s office immediately at 214-369-7881. In the event that the office is closed, I will report immediately to the nearest Emergency Department.

24. I, the undersigned patient, voluntarily attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to voluntarily sign and be bound by this Agreement. I received a copy of this Agreement.

Patient Name (Print): __________________________________________________________

Patient Signature: ___________________________________________________________ Date: ______________

Physician’s Signature: _________________________________________________________ Date: ______________

Witness Signature: ___________________________________________________________ Date: ______________