Controlled substance patient agreement for PCA of Hagerstown

,	, understand and voluntarily agree to the
following. My initials confirm my acceptance of each of	these requirements.
I will keep and be on time for all my scheduled appoint treatment team.	intments with the doctor and other members of the
2. I will not call the office at night or on the weekends to regular business hours- Monday through Friday 9:00am	ooking for refills. Refills will be made only during - 4:00pm
3. I must request refills 5 working days ahead (M-F) for	my medicine.
4. I understand prescriptions will not be given to me mo	ore than 2 days prior to the due date
5. I must keep track of my medications. No early or eme	ergency refill may be made
6. I will treat the staff at the office respectfully at all time or disrupt the care of other patients I will no longer be we	es. I understand that if I am disrespectful to staff elcomed as a patient in this practice
7. If medications are lost or stolen, I understand they ma	ay or may not be replaced
8. I will take my medication as instructed and not chang doctor or other members of the treatment team.	e the way I take it without first talking to the
I will not sell this medication or share with others. I ur will no longer be a patient of this practice	nderstand that if I do, Police will be alerted and I
10. I will sign a release form to let the doctor speak to a	Il other doctors or providers that I see
11. I will tell the doctor all other medicines that I take, ar prescription for a new medicine	nd let him/her know right away if I have a
12. I understand that I may lose my right to treatment in agreement	this office if I break any part of this
13. I agree that I will submit to a blood or urine test if req compliance at my expense	uested by my provider to determine my
Patient signature	Date
Print name	
Witness signature	Date
Print name	
Patient has received a copy / Patient initials	