PRIMECARE OF GEORGIA
LIVE WELL. BREATHE WELL. FEEL WELL
SERENITY MEDSPA
1000 Towne Center Blvd, Suite 604, Pooler, GA 31322 Phone: 912-561-7001 Fax: 912-561-7002
info@primecareofga.com

CONTROLLED SUBSTANCES CONTRACT

The purpose of this contract is to define the expectations between the physician and the patient regarding the use of controlled medications.

I understand that I have a medical condition requiring the use of controlled substances. In addition, I understand that the use of chronic controlled medication carries the risk of addiction as well as side effects from the medication. I understand that controlled medications may impair my ability to operate a motor vehicle or heavy equipment.

To reduce the chances of abuse of the medication, certain parameters regarding the prescription are agreed to:

1. I will not use the medicines at doses higher than prescribed.
2. I will not ask for or receive controlled prescriptions from other medical providers, except as authorized by my physician.
3. I will not ask for early prescription refills. Medications are to be taken as prescribed. Doses may not increased without specific instructions from your provider. Medications must last from one appointment to the next scheduled appointment. If you run out early, the remaining days will endure without medications.
4. No replacements will be provided for lost or stolen medications or prescriptions, even with a police report.
5. While using such medications, I understand that my ability to drive and/or operate machinery or equipment may be impaired. These medications may cause me to feel sleepy and delay my reaction time thus placing others at risk if I ignore these warnings.
6. I understand that my physician will need to see me for regularly scheduled visits, every 1 to 3 months, to follow up on my chronic medical conditions. It is my responsibility to schedule the appointments so that I do not run out of medication.
7. I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my controlled medications and I will notify my physician if I change pharmacies.
8. I will consent to random drug testing. Any tampering with the urine drug screen, such as adding water or other liquids, will result in immediate termination of controlled drugs and you will be dismissed from Prime Care of Georgia.
9. No refills will be made at night, on holidays or weekends. Please be diligent in keeping count of your medication and do not wait until you have 1-2 doses left. I will request medication refills as least 3 business days ahead of the time I will run out.

PRIMECARE OF GEORGIA
LIVE WELL. BREATHE WELL. FEEL WELL
SERENITY MEDSPA
1000 Towne Center Blvd, Suite 604, Pooler, GA 31322 Phone: 912-561-7001 Fax: 912-561-7002
info@primecareofga.com

10. Repeated calls to the office will lead to further delays and practice reserves the right to terminate patient-doctor relationship.
11. Obtaining any controlled substance from any individual is a violation of the law and this contract. Violator will be dismissed from Prime Care of Georgia and reported to law enforcement. Selling any controlled substance to any individual is a violation of the law and this contract. Violators will be dismissed from PCNC and reported to law enforcement.
12. I agree to remain respectful to office staff and providers when requesting refills and refrain from excessively calling the office when requesting my prescription to check the status. I understand that I may leave 1 voicemail and utilize the patient portal to initiate a refill request and will respectfully check with my pharmacy to see if the refill has been sent in.

I have been informed that I may not take other drugs such as stimulants, tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death. I understand that I must not misuse nor share my prescribed medication. Failure to abide by these parameters will be grounds for termination of the prescription of controlled medication by the physician and may result in termination from this practice.

I have read, understand, and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.

_____ _____

Signature **Date**

_____

Printed Name