BRASHEAR FAMILY MEDICAL, P.A.

Benjamin R. Brashear, M.D.
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972-932-8555

CONTROLLED SUBSTANCE CONTRACT

By signing below, I understand that my Provider and I have determined that my health may benefit from appropriate use of one or more medications that are considered Controlled Substances (CS) by the United States Drug Enforcement Agency. (For a complete list of the medications, please see www.deadiversion.usdoj.gov)

I understand that while any improper use of medications can be dangerous, CS medications have a higher likelihood for abuse and misuse. Because of this, I understand that special precautions must be taken when prescribing these substances, and I understand that special care must be taken by me when using, storing and handling CS medications. I understand that the purpose of this contract is to assist my Provider so that together we can maintain a safe and effective treatment plan.

I understand that the possible complications of chronic (daily or regular use for more than 14 days) controlled substance therapy include, but are not limited to: chemical dependence (addiction), overdose, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and/or reduced sexual function.

I also understand that if I take a CS medication in a manner other than what is prescribed, a dangerous situation could result, including, but not limited to: coma, organ damage, or even death. Conversely, I also understand that if I stop or suddenly discontinue a CS medication without my Provider's assistance, I could have withdrawal symptoms which can be hazardous to my health or even fatal.

I understand that if a pregnant woman takes CS medication, there are many potential risks to the health of the unborn child.

The terms of this contract include the following:

1. I will utilize only the Providers at Brashear Family Medical (BFM) for refills or new prescriptions for CS medications for the chronic condition(s) we have discussed.
2. If I am seen on an emergent basis at another facility (such as an Urgent Care center or Emergency Department) and I receive a prescription for a CS for an acute (new) issue, I will notify BFM in a timely manner.
3. I will inform BFM if I am receiving or begin to receive CS medications from another provider for a separate condition that is not under the care of BFM.
4. I will use only one pharmacy for filling controlled substance prescriptions. The pharmacy I have selected is: _____. If I choose to change pharmacies, I will notify BFM in a timely manner.
5. I understand that BFM policy is to see patients regularly if they are prescribed CS for chronic conditions. I understand that each case is considered unique and very frequent visits may be required, but at a minimum, I know I will need to be seen in the office at least once every 3 months.
6. I understand that if a refill of a CS is requested prior to my next scheduled appointment, I may be asked to appear in person at an office visit prior to the refill being granted.
7. I understand that some CS medicines may require a hand written prescription by a physician, and I will allow an appropriate amount of time for these to be handled and processed by BFM.
8. I understand that BFM policy is to expect at least 2 business days to handle refills on most prescriptions, but I know that I will need to allow at least 5 business days to process a refill request for most CS medicines.

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9. I understand that the physician on call (after regular office hours and on weekends) will NOT fill my controlled substance medications.
10. I agree to allow BFM staff and providers to communicate with any and all Medical Providers, clinics, hospitals, urgent care centers, pharmacies, or other Healthcare entities regarding my use of controlled substances.
11. I agree to take the controlled substance medication exactly as directed.
12. I agree that Brashear Family Medical will NOT replace any lost or stolen CS medications.
13. I understand that the benefits of controlled substance medications will be evaluated regularly using the following criteria:
    a. increase or improvement in function/mobility
    b. increase or improvement in activities of daily living
    c. absence of unacceptable side effects
    d. if appropriate, return to work and/or improved effectiveness at work
14. I agree to periodic laboratory screens (e.g. Urine testing, blood draws, etc.) for other CS medications and drugs of abuse. I understand the frequency of these screenings will be at my Provider's discretion, but will occur at least annually. I understand that if there is an unexpected result on laboratory screening, I may not receive a new prescription for 30 (thirty) days, and then a new office visit must be scheduled to determine if further CS prescriptions will be given.
15. I am NOT currently abusing or misusing prescription CS medications.
16. I do NOT use illegal substances.
17. I am NOT currently undergoing treatment for substance dependence or abuse.
18. If I have ever been treated for substance abuse of any kind, my Provider is fully aware of the circumstances and timing of this treatment plan.
19. I am NOT, nor have I ever been, involved in the illegal sale, possession, or transport of any illicit or prescription drugs.
20. If I am a woman of child-bearing age, I am not pregnant and I will inform the provider if I become pregnant.
21. I understand that concurrent use of alcohol, sedatives, and/or other substances or prescriptions can increase or alter the effects of CS medications and may cause dangerous or life threatening side effects.
22. I understand that use of CS medications may cause me to be impaired so that I cannot operate a vehicle or other heavy equipment safely.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract.
If any part of this contract as outlined above is broken, I understand that it may result in my dismissal from Brashear Family Medical and/or temporary or permanent discontinuation of BFM providing controlled substance prescriptions.

_____ _____
Patient Full Name Date of Birth

_____ _____
Patient Signature Date

_____ _____
Provider/Witness Signature Date