Intensive Health
a stepworks company

Controlled Substance Contract

Patient Name: _____ Date of Birth: _____ / _____ / _____

I agree to abide by the following guidelines for managing my prescriptions from Intensive Health. Intensive Health includes the following providers: Thomas Ingram MD, Gregory Smith MD, Joyce Johnson APRN, Jen Cothern APRN, and Kimberly Gambino, APRN.

I understand that I am only to receive controlled substances from these providers unless discussed beforehand.

I agree to inform any other providers (to include any specialists, dentists, etc.) involved in my care of my agreement with Intensive Health. If another provider wishes to suggest changes in my treatment plan involving controlled substances, they can contact Intensive Health during regular business hours. However, no changes will be made without the other provider contacting this office.

I understand that if my medicines are lost or stolen, they will not be refilled prior to the next refill date. I will not request refills prior to the refill date. If I use up my supply of medication before the date of the next refill, I understand that my provider will not provide extra medication. Further, I understand that I may suffer withdrawal symptoms if I run out of my medication early. If I have difficulty taking the medication as prescribed I will discuss this with my provider at a scheduled office visit.

I understand that my provider may require monitored or unmonitored drug screenings and pill counts as part of my controlled substance contract. I may be required to do random drug screens. If asked to complete a random drug screen, I understand that these must be completed within 24 hours of the request or by the time line indicated by the provider. If I fail these drug screenings at any time during my treatment with Intensive Health, the provider has the right to discontinue prescribing controlled substances for me. I understand that when I am asked to provide a drug screen I am unable to leave the office for any reason and if I leave the office that my drug screen will be considered as failed. I understand that, if I am called for a random drug screen and do not attend, I will be required to see the counselor and revert to more frequent visits.

Initial the following:

_____ I agree not to abuse alcohol or other illicit drugs.

_____ I will not sell or share controlled substance medications. I will not take more medication than is prescribed.

_____ I will use the following pharmacy to fill all of my controlled substance prescriptions:

Pharmacy: _____

If I violate the terms of this contract, I understand that the providers at Intensive Health may no longer prescribe controlled substance medications for me. If this occurs, I understand that I may receive my care elsewhere. I may also continue with my current provider, but I will not receive controlled substance medications from Intensive Health. If I change providers, I agree to allow my current provider to contact my new provider to transfer medical information, including information about my controlled substance prescriptions.

Patient Signature: _____ Date: _____ / _____ / _____

Provider Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Date: _____ / _____ / _____