accura health
primary & post-acute care management

ANAND BALASUBRAMANIAN MD PA **MICHAEL OLATUNJI MD**

CONTROLLED MEDICATION PATIENT- PROVIDER AGREEMENT

Purpose:
This agreement is designed to maximize your safety with controlled substances and minimize the associated risks, such as abuse, addiction, and serious side effects. Controlled medications may be used as a therapeutic option for managing chronic conditions, but they can have significant risks, including gastrointestinal issues, cognitive deficits, psychiatric changes, respiratory and cardiac problems, and even death.

Patient Agreement

I, _____, understand that my provider has agreed to prescribe controlled substances for my chronic conditions. I agree to abide by the following guidelines while receiving these medications and understand that failure to follow this agreement may result in the discontinuation of medications and/or discharge from the clinic.

Responsibilities and Guidelines:

1. **Medications and Dosing:**
   - I will take medications **only at the prescribed dose and frequency**. Any changes must be approved by my provider.
2. **Provider Exclusivity**:
   - I will receive controlled medications **only from my provider** and not from anyone else, including the emergency department.
3. **Notifying Other Providers:**
   - If I receive controlled medications from another provider (e.g., emergency department or dentist), I will notify my provider within **72 hours.**
4. **Refills**:
   - Refills will **not be called, mailed**, or **faxed**. I must visit the clinic regularly for prescriptions.
5. **Testing and Compliance**:
   - I will adhere to **random urine drug tests**, **blood tests, pill counts**, and any other testing requested by my provider. I agree to bring my medication bottles if asked. Failure to comply may result in discontinuation of medications and/or discharge.
6. **Medication Protection**:
   - It is my responsibility to **protect my medications** from loss, theft, or damage. I understand that replacements are **not routinely given** and will require an office visit. If medications are stolen, they may lead to **discontinuation of medications** or discharge.

accura health
primary & post-acute care management

7. **Appointment Scheduling:**
    - I understand that refills and medication changes, including discontinuation, will only be made during **scheduled appointments.** I **will schedule appointments in advance** and understand that these changes will not be made over the phone except under **extenuating circumstances**.
8. **Medication Safety Classes**:
    - I may be asked to attend **controlled medication classes** to improve my understanding of chronic conditions and medication safety. I will adhere to other aspects of my care as discussed with my provider.
9. **Appointment Cancellations:**
    - I agree to **cancel appointments at least 24 hours in advance**. **Excessive cancellations** or failure to follow up regularly may result in discontinuation of controlled medications.
10. **Side Effects and Caution:**
    - I understand that these medications may cause **drowsiness**, **dizziness**, **impaired cognition**, or **motor skills issues**. I will avoid driving or operating heavy machinery if these effects occur and will notify my provider.
11. **Medications and Sharing**:
    - I agree not **to sell, lend, or give** my medications to anyone else. My prescriptions **will not be shared** with others.
12. **Substance Use:**
    - I agree **not to consume alcohol** or take any **other mood-altering drugs** while taking controlled medications, unless cleared by my provider. I will **not use illicit/illegal substances**, including marijuana, methamphetamines, cocaine, heroin, or any other illegal substances.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider Name: _____

Provider Signature: _____

Date: _____

Accura Health Sunnyvale Clinic

3635 North Beltline
Ste 110 Sunnyvale, TX 75182
TEL: 972-216-1500