

Each patient we serve must review and sign the following collaborative agreement prior to proceeding with controlled treatment at Horizon Healthcare. This agreement is required to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstandings about any treatments patients receive. Because a Horizon Healthcare provider may be prescribing such medication as part of your plan of care, you must agree to this contract. Horizon Healthcare will follow federal guidelines for prescribing controlled substances. Patients must acknowledge that complete lack of pain, anxiety, and other symptoms is not realistic. **I understand that the main goal of treatment is to improve my ability to function or work.** Controlled substances such as Schedule II and Schedule III drugs have high abuse & misuse potential. Examples include but are not limited to the following: Opioids such as Hydrocodone/Oxycodone/Tramadol, Muscle Relaxants such as Meloxicam/Flexeril, Nerve Pain Medications such as Gabapentin/Lyrica, Hormones such as Testosterone, etc. Controlled medications have potential risks associated with their use, including but not limited to the following: drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowed breathing rate, slowed reflexes, physical dependence, tolerance to analgesia, and addiction (or possibly death). **Males** may have low testosterone, decreased sexual desire, decreased stamina, and decreased physical/sexual performance. **Females** are responsible to immediately notify the prescribing Provider and their Obstetric Doctor if they become pregnant while taking a controlled substance medication. Patient is aware that should the baby be carried to delivery while taking these medications, the baby may physically be dependent upon opioids and may be associated risks of birth defects.

1. I agree that I will use my medication ONLY as prescribed by my doctor. I understand that any change to my prescriptions will require a doctor's visit. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends. I will call at least 3 business days before my prescription runs out. I am aware no refills or dose increases over a phone call will be authorized
2. I understand I am not authorized to the use of any illegal controlled substances including but not limited to marijuana, cocaine, methamphetamines, heroin etc. Certain forms of marijuana are legal but may interact with controlled substances. Personal use of marijuana must be discussed with the provider before controlled substances are prescribed. Failure to follow policy may result of dismissal of practice or discontinuation of the controlled substance being prescribed by a Provider at Horizon Healthcare.
3. Noncompliance with the terms in this contract may result in re-evaluation of treatment plan; discontinuation of opioid therapy, stimulant treatment, or Benzodiazepine treatment; and/or dismissal from the practice. I understand if I do not follow the plan of care set forth by the prescribing Provider, the Provider is not obligated to provide medication other than a temporary amount (only if deemed medically necessary) to prevent withdrawal effects.
4. I agree to submit to a Random or Scheduled blood test, or urine drug test, if requested by my provider, to determine compliance with my program of pain medication.
5. If patient's medication is stolen, a police report may be given to the prescribing Provider for consideration of an early refill. It is at the provider's discretion whether a refill will be given to the patient. A refill due to loss or theft is not required and may not be approved. A second theft or loss occurrence may result in discontinuation of medication or dismissal from the practice. I understand that lost or stolen medication or unfilled prescriptions WILL NOT be replaced, and I will safeguard my medication from theft.
6. I understand that I will follow the guidelines on properly disposing of controlled substances that will be explained to me by clinical staff. I will not alter the form of the medication, nor will I take the medication in a route other than as prescribed by my provider. I will not discard, flush, give away or in any way lose control of my medications. I will not share, sell or trade my medications with anyone. Additionally, I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person. In the event of an emergency, if I do obtain controlled substances from another provider, I understand I am required to disclose this information to Horizon Healthcare within 48 hours of hospital discharge or emergency service. I understand it is my responsibility to make sure Horizon Healthcare is notified of any such treatments and that I am to check with staff before combining any pain medication with the prescriptions Horizon Healthcare provides me.
7. I will notify Horizon Healthcare of any change in name, address or phone number. I understand that I must at all times have an updated phone number with my provider. I cannot be on dangerous medications, such as opioids, if my provider cannot reach me in a reasonable period of time (usually considered within 24 hours of the initial attempt). I agree to return any phone call from Horizon Healthcare within 24 business hours.

8. I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state or federal law enforcement agency, including this state's Board of Pharmacy.
9. I understand that any follow-up appointment for controlled substances must be scheduled before leaving the clinic or within 3 business days after to guarantee appointment. Additionally, I understand that refusing to see one of Horizon Healthcare providers will likely result in my no longer being able to be treated by the practice as I may be asked to see a Nurse Practitioner or Physician Assistant.
10. Patient must stay compliant with all treatment recommendations pertaining to chronic diagnosis correlating with controlled substance prescribing reasons such as counseling, physical therapy, nonnarcotic medications, etc. Primary Care patients must keep and maintain age appropriate routine/preventative appointments and diagnostic orders
11. Pharmacies have medication supply chain disruptions. If you accept the partial fill, you must schedule another appointment for a separate script to be given for the remainder of the medication quantity originally prescribed. New scripts for partial fill will not be completed by phone call. It is recommended that you call the pharmacy to verify if a medication is in stock prior to appointment for refill. Then, if you note that your usual pharmacy is out of stock, you can update this agreement with the correct pharmacy you intend to use for the prescription refill. I understand that the clinic does not mail narcotic prescriptions under any circumstances.
12. I understand that the combination of controlled substances and alcohol/illicit substances are contra-indicated; the combination may result in serious harm or even death. Narcan Nasal Spray prescription has been provided to me for emergent use or may be accessible at pharmacy/ healthcare facility. (1 actuation in one nostril 1 time, may repeat dose in alternate nostril 2-3 minutes until patient is responsive or Emergency Management Services arrives.) Space with any use of benzodiazepine and any opioid at least 3 hours apart.
13. I understand that non-professional or inappropriate behavior toward any Horizon Healthcare staff, affiliate or provider will not be tolerated. I agree to be respectful to other patients I may encounter in the waiting room, lobby, hallways, etc. I understand that I may not loiter in the parking lot of any Horizon Healthcare location. I understand that Horizon Healthcare providers utilize tests to determine the best option for my care. My unwillingness to complete the tests requested may result in being released from further care with Horizon Healthcare. I understand that non-compliance with my pain management treatment plan may result in provider's inability to properly treat my symptoms and could cause symptoms to worsen or become life threatening. I understand that I may be released from this practice for missing appointments or cancelling/rescheduling appointments with less than 24-hour notice.
14. I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.
15. Patient has designated one and only one preferred pharmacy that must be in the state of Illinois. Once a prescription has been filled, all questions regarding that prescription should be directed to that pharmacy. Our practice will only fill with this pharmacy. Name and location: _____.

I understand that, if I violate any of the above conditions, my controlled substance prescriptions may be immediately terminated. If the violation involves obtaining controlled substances from another individual, or providing controlled substances to another individual, I may also be reported to my other healthcare providers, medical facilities and law enforcement officials. I have read this contract and have also been informed regarding psychological physical dependence to controlled substances and agree to inherent rules as above.

Patient Name (Printed): _____ DOB: _____

Signature of Patient(or Parent if patient is a minor): _____

Date Signed: _____

Copy given to pt: [] Initial _____