LISA LARKIN • MD
&
ASSOCIATES

1. By signing this agreement for controlled substances, I agree that I understand the discussion of the use of controlled medications, including the side effects, and I wish to start this medication under the terms of Lisa Larkin, MD, and Associates.

2. All controlled substances must come from the provider whose signature appears below, or during his/her absence, by the covering practice provider.

If you are receiving ANY controlled substances from another provider outside of this office, please list the medication and provider here:

_____

_____

3. I agree that I will fill my controlled medication prescriptions from ONE PHARMACY only. Under no circumstances will I obtain controlled medications from more than one pharmacy at a time.

Pharmacy Name: _____

Phone #: _____

4. If you have obtained prescriptions for controlled substances from somewhere other than Lisa Larkin, MD, and Associates, without written permission, this agreement may end and no further prescriptions for controlled medications will be given.

5. There may be an initial point of care urine drug screen done at the time of the contract, at the cost of $20 billed directly to patient. Random point of care urine screens will be conducted at the discretion of the provider, also billed to the patient. If this test indicates illegal/non-prescribed drug use, or the absence of prescribed medications, we will confirm these results with serum blood test and will await confirmatory results before making a determination if future controlled medication prescriptions will be written by our office.

6. To comply with government requirements, an OARRS and Kasper report will be run at least every three months to track prescribed prescription history of the patient.

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7. If the medication is lost or stolen, the prescription will NOT be replaced. It is your responsibility to protect and secure these controlled medications. This includes keeping controlled medication out of reach of children and pets.

8. It is a violation to alter a prescription in any way. Any alteration of a prescription is a violation of this agreement and is grounds dismissal from the practice as well as for legal action.

9. I understand that if there is indication that I may be selling these medications, that the office is REQUIRED by law to report this to the authorities.

10. **I agree to be seen every 3 months for my controlled medication use (or per my provider's discretion)**. If there are 2 appointment cancellations or 2 no-show appointments related to the controlled medication, this constitutes grounds for termination of this agreement and possible termination from the practice.

Under this agreement, I understand that if my actions cause legal authorities to ask questions about my treatment with controlled medication, all confidentiality is waived. These authorities may be given full access to my prescription records and medical records related to my treatment with controlled medication. I also understand that any information about illegal drug-related activity on my part may be reported to appropriate law enforcement agencies.

I understand that by signing this agreement, I must abide by these rules reviewed above and that failure to abide by these agreements will results in termination of controlled medication prescriptions and possibly termination of services from my healthcare provider and her practice.

_____ _____
Patient Signature Date

_____ _____
Healthcare Provider signature Date