Informed Consent and Contract for Controlled Substance Prescriptions

The purpose of this agreement is to provide informed consent regarding use of controlled substances such as but not limited to the following as defined by the Drug Enforcement Agency (DEA):

- Opioid Pain Medication (ex: morphine, hydrocodone, oxycodone, dilaudid, fentanyl, etc.)
- Benzodiazepines (ex: alprazolam, clonazepam, lorazepam, diazepam, etc.)
- Stimulants (ex: Adderall, Ritalin, etc.)
- Anabolic Steroids (ex: Testosterone , Depo, etc.)

The goal of this contract and informed consent is to educate on safe controlled substance use and establish guidelines for controlled substance prescriptions to aid in both patient safety and ensure clinic adherence to all state and federal regulations.

By reading and signing this informed consent and contract for treatment, I, the patient/medically responsible party, agree to the following:

1. The patient or medically responsible party is solely responsible for the controlled substance prescription. The prescribing provider and affiliated clinic is NOT responsible for any lost, stolen, or misplaced prescriptions.
    a. Stolen prescriptions should be reported to the Police immediately. Unfortunately, a stolen prescription will not be refilled until the next regularly scheduled refill is due - you should contact your provider immediately so that further direction can be provided.
2. I understand that controlled substance prescriptions will be dispensed for a maximum of 30 days at a time and that frequent interchanges between

pharmacies is not allowed. Once the prescription is sent, the pharmacy will not be changed until the next scheduled prescription.

3. The patient will agree to take the medication only as prescribed and that any increase, decrease, or discontinuation must be discussed with the provider PRIOR to any change in dose. Running out of a prescription PRIOR to your next refill due to taking medication sooner than prescribed is a VIOLATION of this pain contract and could lead to discontinuation of your prescription.
    a. I understand that decreasing or stopping medication without the close supervision from the prescribing provider could lead to withdrawal. Withdrawal symptoms can include but are not limited to the following: anxiety, excessive sleepiness, yawning, sweating, watery eyes, runny nose, tremors, muscle aches, hot/cold flashes, “goose flesh”’, abdominal cramps, and diarrhea.
4. I will not request or accept controlled substance prescriptions from any other provider or individual while I am receiving controlled substances from my current health care provider. Any recommendations for controlled substance prescriptions from specialists or outside providers should be sent in writing to our clinic via fax at 913-681-2416.
5. I understand that controlled substance prescriptions are solely for the individual the medication is prescribed. The controlled substance should NEVER be shared, given, or sold to others as it could endanger their health and is against the law.
6. In order to receive my controlled substance prescription, I understand that I need to have completed the following PRIOR TO the release of my prescriptions:
    a. Drug screening within the last 6 months without evidence for illicit/illegal drug use or non-prescribed controlled substance use.
    b. Visit with a provider affiliated with our clinic either via home visit or telehealth visit in the last 30 days.
    c. Imaging supporting concerns regarding pain medication or a visit note from previous provider documenting need for controlled substance therapy.
    d. Narcan prescription sent within the past year.
7. I understand that I am responsible for scheduling monthly appointments for controlled substance monitoring.
8. I will communicate fully and in a timely manner with my provider regarding any side effects and functional activity affected by use of my controlled substance prescription.
    a. Side effects of controlled substance use may include but are not limited to the following: skin rash, constipation, sexual dysfunction, sleeping

abnormalities, sweating, swelling, excessive sleepiness/sedation, impaired cognition, forgetfulness, addiction, etc.

b. Overuse of controlled substances can lead to decreased respirations, decline in overall condition, and potentially death.

9. If I do not require as many tablets as prescribed, I will notify my provider immediately so that my dose/amount prescribed can be decreased to meet my needs. Any evidence of drug hoarding, acquisition of any controlled substances from other providers to include Emergency Room visits, uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow this agreement will result in termination of controlled substance prescription.
10. I understand that any use of illicit/illegal substances such as but not limited to cocaine, LSD, methamphetamine, heroin, and non-prescribed controlled substances will result in termination or non-initiation of controlled substance prescriptions.
11. I understand that the use of alcohol in conjunction with controlled substances is contraindicated and that testing positive for alcohol, evidence of excessive alcohol use, intoxication, and/or impairment will lead to termination of the controlled substance prescription.
12. I understand that refill requests will be sent within 2 business days and that “Emergency/Rushed Refills” will not be sent as we are not emergency services but Primary Care. Appointments may take several days due to the number of patients we care for so it is up to the patient/responsible party to plan accordingly.
13. I understand that controlled substance prescriptions can only be sent in the state of Kansas or Missouri as these are the states we currently practice in, and that accommodations can not be made for patients traveling out of town for any reason.
14. New prescriptions or prescriptions that have never been sent by our clinic require a provider visit and proper supporting documentation to include the following:
    a. Completed and resulted drug screen
    b. Imaging if applicable
    c. Supporting provider documentation from previous provider (ex: PCP, orthopedist, Pain Clinic, Psychiatrist, etc)
15. I understand that a missed appointment for prescription refill will require another appointment as soon as possible but will be provided based on scheduling availability. Please make every attempt to keep your appointment as a missed appointment may lead to a delay in your prescription refill.
    a. Emergency/immediate appointments and walk-ins will not be granted.

16. I understand that unsolicited visits to the office to request a controlled substance refill/prescription will not result in a prescription or a visit and may lead to termination of the patient/provider relationship.
17. I understand that any signs of addition, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning/detoxification.
18. I understand that any history of violated controlled substance policies, drug abuse/misuse, alcohol or drug addiction must be disclosed to the provider. Failure to disclose may result in termination or refusal to initiate a controlled substance.
19. I agree and understand that my provider reserves the right to perform random or unannounced drug testing and that refusal to provide a sample may result in termination or refusal to initiate controlled substance prescriptions.
20. I agree to allow my provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my medical care or actions.
21. I understand that non-compliance with the above conditions as listed in this informed consent and contract may result in termination or refusal to initiate a controlled substance prescription and potentially discontinuation of the provider/patient relationship.

I, _____, have read the above information and indicate understanding and compliance with the stated terms of this agreement. I hereby give my consent to participate in the clinic's controlled substance program.

Patient/Responsible Party's name:
_____

Patient/Responsible Party's signature:
_____

Date: _____

House Calls KC
400 E Red Bridge Road, Suite 207
Kansas City, MO 64131-4029
Email: primarycare@housecallskc.com

Home Based Primary Care
Phone: 913-681-2398
Fax: 913-681-2416
www.housecallskc.com