PATIENTS NAME _____ DOB _____ Revised 6/24/2013

ADULT MEDICINE OF LAKE COUNTY, INC.

3619 Lake Center Drive, Mount Dora, Florida 32757 352-383-8222

CONTROLLED SUBSTANCE AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines prescribed by your physician. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these medicines.

In some cases, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended. If the drug does not show up in my sytem no taper off of the drug is necessary.

I will communicate fully with my doctor about the character and intensity of my pain or abnormal condition, the effect on my daily life, and how well the medicine is helping to relieve the pain or address the abnormal condition.

I will not use any illegal controlled substances, including marijuana, cocaine etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicine, controlled stimulants, and anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of controlled substance medicine.

The results of the required drug screen tests are a part of your medical record, but isolated in your file from release to parties requesting records unless a separate written permission is signed by you.

However, I authorize the doctor to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my prescription..I authorize my doctor to provide a copy of this agreement when requested. I agree to waive any applicable privilege or right of privacy, or confidentiality with respect to these authorizations.

I agree to follow these guidelines and a copy of this document has been given to me.

This Agreement is entered into on this_____day of _____, 20____.

Patient Signature_____

Physician Signature_____Witnessed by: _____