Blackhawk MEDICAL GROUP

Medication Contract

Patient Name _____ **Diagnosis** _____

I agree to abide by the following guidelines for managing my controlled substance prescription(s) including opioid pain medicines, controlled stimulants, or antianxiety medications:

1. I will only request and receive the controlled substance medications(s) listed below from the signing provider below or from his/her designee **during scheduled office hours. No refills will be available at the Walk-in Clinic or during evenings, weekends or holidays.** I agree to inform all other physicians participating in my care of this agreement.

Medication	Dose	Directions	Quantity / Month
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. **I will not request refills prior to the next refill date listed on the bottle.** I understand that if my medicines are lost, destroyed or stolen, they will not be refilled prior to the next refill date. If I use up my supply of medication before the date of the next refill, I understand that my provider will not provide extra medication.

3. I agree to have all of my controlled medicine prescriptions filled at:

Pharmacy Name	Pharmacy Address	Phone & FAX
_____	_____	_____

4. I will not sell or share opiate medications, or any other controlled substances. I will not use any illegal controlled substances.

5. I agree to submit to a blood or urine drug test if requested by my provider to determine compliance with this Contract.

6. If I violate the terms of this contract, I understand that my relations with the healthcare providers at Blackhawk Medical Group may be terminated and I may be reported to the drug enforcement authorities, other physicians, and local medical facilities.

I authorize Blackhawk Medical Group to provide a copy of this agreement to my pharmacy and to cooperate with any law enforcement agency in the investigation of any possible illegal use, sale or other diversion of my controlled medication. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this authorization. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

_____	_____	_____
Patient Name (Print)	Date	Patient Signature
_____	_____	_____
Provider Name (Print)	Date	Provider Signature
_____	_____	_____
Witness Name (Print)	Date	Witness Signature