

PATIENT-PROVIDER CONSENT FOR CONTROLLED SUBSTANCE MEDICATIONS

Patient Name: _____

Date of Birth: _____

Healthcare Provider: **Healthy Wings, LLC, its affiliates, assigns, and/or licensed healthcare providers.**

1. **Required Healthcare Provider Team Members:** I agree to maintain a primary care provider while I am receiving controlled substances.
2. **Addiction Potential:** I understand that addiction is real risk associated with controlled substances and I am accepting of this risk. I will not hold the Healthcare Provider, Healthy Wings Family & Psychiatric Healthcare, Healthy Wings LLC, their officers, assigns, and/or employees or contractors, responsible for the addiction.
3. **Substance Abuse Prohibited:** I understand that I am absolutely prohibited from abusing alcohol, marijuana, other recreational drugs, or other prescription drugs while under the treatment of the Healthcare Provider named above. Random monitoring may be necessary at the Healthcare Provider's discretion, please see Section 7 below.
4. **Getting Controlled Substances elsewhere is prohibited except for special circumstances:** I will not get controlled substance from other healthcare providers except in the case of another medical specialty (i.e., primary care, psychiatry, pain management, an emergency or surgery). If an emergency occurs, I will contact my healthcare provider immediately following the emergency. I agree to discuss all prescribed controlled substance with my Healthcare Provider. I agree not to "shop" for controlled substances or other non-controlled muscle relaxants, neuropathic or joint pain relievers, from other healthcare providers and for continuity of care. I give the Healthcare Provider named above permission to speak with any and all other healthcare provider regarding my controlled substance and/or other prescriptions.
5. **I will not take more medication/increase my dose without permission:** I agree not to take more than the dose prescribed until my next visit with the Healthcare Provider listed above. For safety purposes, no significant medication changes will be made over the telephone. I will not be given more medication if I run out early or suffer a loss or theft of the controlled substances.
6. **Allergy or significant side effects to medications:** I understand that controlled substances may cause nausea, vomiting, constipation, tolerance, dependence, addiction, respiratory depression, drowsiness, mood changes, anxiety, mental clouding, and problems with urination, jerkiness, and even death. I agree to contact the Healthcare Provider listed above if I experience any these symptoms.
7. **Monitoring of Medications Use:** I understand that controlled substances will be strictly monitored including via the Arizona Prescription Monitoring Program, random drug testing, and pill counts. I agree to present to the clinic within 24 hours of a request for random drug testing or pill counts. I agree to use only ONE pharmacy for controlled substances, and I will contact the Healthcare Provider listed above if there are any changes.
8. **Medication Theft or Loss:** I understand that the Healthcare Provider listed above will not replace lost, stolen, or spilled medications or prescriptions.

9. **Forgery, Altered Prescriptions, Giving Away, or Selling Medication is Forbidden:** I understand that this is a federal crime that is subject to prosecution.
10. **Failed Compliance:** I agree to follow the treatment plan as determined by my Healthcare Provider, including the required work-up, trying alternative treatments to controlled substances, and keeping my scheduled appointments. I will miss no more than three (3) appointments during the course of my patient-provider relationship, and refills, if required, will not be fulfilled without an appointment for medication evaluation as stipulated by the Healthcare Provider listed above.
11. **Pregnancy:** I agree to inform the Healthcare Provider listed above if I become or plan to become pregnant as controlled substances may affect the fetal health and result in dependency at birth.
12. **Safety Issues:** The Healthcare Provider listed above reserves the right to reduce or stop the controlled substances if there is a concern for the patient or involved party's safety. This includes felony charges, convictions, and/or imprisonment. I understand that the Healthcare Provider will not tolerate lies, misrepresentations, or deception as well as rude, obnoxious, threatening, or belligerent behavior to ensure the safety of the patient, clinic staff, and/or other patients.
13. **Patient Responsibility:** I have discussed the side effects and risks of the medications with Healthcare Provider listed above. I understand that taking controlled substances with sedatives (i.e., Alcohol, Valium, Ativan, narcotics, etc.) presents a significant health risk including death. I understand that abrupt discontinuation of controlled substances after 24-48 hours may result in withdrawal symptoms.
14. **Trial Period:** I agree that if a trial of controlled substances does not result in improvement and functional benefit I will taper off as directed by the Healthcare Provider listed above.

I agree and consent to the terms documented above, and I understand that violation will result in termination of the professional medical relationship between myself, the patient, and the Healthcare Provider listed above for the prescribing of controlled substances.

Print Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Date: _____

Healthcare Provider's Name: _____ MRN: _____

Healthcare Provider's Signature: _____ Date: _____

Witness: _____ Date: _____

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