perlmanclinic++

MEDICATION AGREEMENT

Please note: if you submit this form online, it will automatically be emailed to medicalrecords@perlmanclinic.com. Please be advised that email is not secure for HIPAA-protected information. To send this securely, please print and fax it to 858-795-1195 or upload to your MyChart.

DOB: _____ Name: _____ Phone #: _____

Provider: _____ Clinic: PERLMAN CLINIC

I,_____, understand that the purpose of this Agreement is to help me and my provider comply with Perlman Clinic's Controlled Substance policies which are based on treatment guidelines by the state of California. I recognize that controlled medications have both risks and benefits, which have been explained to me by my provider, and that any controlled medications are only one part of patient treatment.

Any controlled medications I receive and the reasons why I receive the medications will be fully documented within the electronic medical record system (EMR) by my provider.

I understand that to be eligible to receive controlled medications by my provider, I agree to the following:
Please initial each line in agreement to the statement:

_____ I will receive this medication ***only from my primary provider (or their designated covering provider if unavailable for over 72 hours)*** and from no one else (ER staff, psychiatrists, etc.). If I am prescribed a controlled substance for any reason from any other provider (ER, Dentist) I will notify my provider within 72 hours.

_____ Medicines will be used ***only*** as directed. I will ***NOT***:

a. Use them other than for treating my condition
b. Increase the dose without talking to my provider
c. Share, sell, or trade them with others

_____ I understand I must do an office or video visit **at least every 90 days** for refills on my medication. Refills between visits will be requested at least 72 hours in advance via mychart messaging to my provider. ***It is up to me to make it to the appointments. If I do not come as scheduled I will have to go without my prescription until I am able to reschedule with my provider.***

_____ Due to concerns regarding addiction and tolerance, the goal is to use the lowest dose possible to achieve the desired effect.

_____ I will not use any illegal drugs and will take a ***random drug test*** by urine or blood sample if my provider asks me to.

_____ It is ***my responsibility*** to protect my prescriptions from loss, theft, or damage. Refills will not be given for lost or stolen medications. I will bring all unused medications to every office visit.

_____ These medicines are only one part of my treatment strategy. I agree ***to follow all other parts of my care*** as discussed with my provider. This will be fully documented within the EMR system by my primary care provider.

_____ The medicine must help me to function better. Based on my activity or general function level, the medicines may be changed or stopped.

I understand that violation of any one of the above points may result in stopping any controlled medications. I understand that abusive behavior toward staff or providers will result in dismissal from treatment at all Perlman clinics. I acknowledge I received a copy of the agreement.

Any changes to the medication regimen will be recorded within the EMR system.

Patient Signature: _____ Date: _____