Reservoir Family Medical Clinic

Phone (601) 991-6511 ~ Fax (601) 992-5684

Controlled Substance & Prescription Agreement

The purpose of this agreement is to prevent misunderstanding about certain controlled substances (such as pain medications, stimulants, muscle relaxants, sedatives, etc.), to protect your access to these medications, and to protect our ability to prescribe them to you. **Controlled medication(s) will only be provided if you follow the rules specified in this agreement. All statements must be read and initialed for this agreement to be valid.**

_____I understand that some medications may impair alertness, judgement, and coordination, and that it is illegal to operate a motor vehicle when the ability to drive is impaired by such medications.

_____ I understand that chronic use of these medications can result in physical and/or psychological dependence and addiction and that abruptly stopping these medications could result in unpleasant withdrawal side effects.

_____ My progress must be periodically reviewed, so an office visit is always required before refilling a controlled substance. If the medication is not working or improving my quality of life, the medication may be discontinued.

_____ Any changes in prescriptions or refills on controlled substances will only be made during scheduled appointments, not via phone or pharmacy request.

_____ I will not attempt to obtain any controlled medication(s) from any other health care provider while under the care of Dr. Crenshaw, and I will communicate fully and honestly with him about my conditions and disclose to him all medication(s) prescribed by other doctors.

_____ I understand that routine drug screens will be required to determine compliance. Drug screens are required by some insurances before they will pay for some medications. I agree to cooperate with the office staff fully when a sample is requested, and I understand I will be financially responsible for any test ordered.

_____ I understand that prescriptions written to be taken “as needed“ are only to be taken IF NEEDED and are not to be taken more frequently or in any other manner (crushing, chewing, etc.) than prescribed.

_____ I agree not to sell, share, trade, or otherwise permit others to have access to prescriptions or medications. Medications will be kept in a secure place and away from children.

_____ I understand that prescriptions and medications are exactly like money; if they are lost or damaged, they cannot be replaced. If a prescription is stolen, a police report should be filed and a copy brought to Dr. Crenshaw.

_____ I understand that forging or altering a prescription (date, quantity, strength, etc.) in any way is against the law and any evidence of this will be turned in to the proper authorities.

_____ I understand that timely requests for refills are solely the patient’s responsibility and early refills will not be given. Appointments for refills should be scheduled in advance, as we no longer take walk ins.

_____ I agree to check for errors on my prescription(s) before leaving the clinic and to check my medication bottles before leaving the pharmacy. No medications can be returned once I have left with them.

_____ I understand that my prescription(s) may require a Prior Authorization (PA) from my insurance company before they will pay for some medication(s). It usually takes about 7-10 business days. I understand that the clinic may be required to submit records, drug screen results, etc to my insurance company for them determine coverage. If insurance does not cover my medications, I have the option to pay for them out of pocket.

_____ I understand that Dr. Crenshaw cooperates fully with local law enforcement regarding prescription medications and is obligated to report any misuse, sale, or other diversion to the authorities.

_____ I agree to use _____ pharmacy located _____ for my medications, whenever possible. Should the need arise to change pharmacies, I will inform my physician in writing.

_____I agree to follow these guidelines and understand that failure to adhere to these policies may result in cessation of medications or dismissal as a patient. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all the terms noted above.

Patient name: _____ Date of birth: _____

Signature: _____ Date: _____

Please note: If you think you have a problem or are becoming dependent on medication, please discuss this issue with the doctor or staff. There are treatment options to help wean you off these medications, and we would be happy to discuss them with you.

Witness signature: _____Date: _____