MIRACLE Counseling

MEDICATION MANAGEMENT PATIENT AGREEMENT

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MEDICATION MANAGEMENT: PATIENT AGREEMENT

I, _____, understand and voluntarily agree that (initial each statement after reviewing):

_____ I will keep (and be on time for) all my scheduled appointments with the provider and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the prescriber or other member of the treatment team.

_____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the provider speak to all other doctors or providers that I see.

_____ I will tell the provider all other medicines that I take and let him/her know right away if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all on my medicines: _____
Pharmacy name/phone#

_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____ I will keep up to date with any bills from the office and tell the provider or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

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MIRACLE COUNSELING TREATMENT STATEMENT

We here at Miracle Counseling are making a commitment to work with you in your efforts to get better.

To help you in this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set treatment goals and monitor your progress in achieving those goals.
- We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

_____	_____	_____
Patient's Signature	Patient Name Printed	Date
_____	_____	_____
First Provider's Signature	Provider Name Printed	Date
_____	_____	_____
Second Provider's Signature (If necessary)	Provider Name Printed	Date

Adapted from the American Academy of Pain Medicine http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203- 09/12-22– MC–LE

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AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

Patient Name: _____

The use of _____ may cause addiction and is only one part of the treatment for: _____ (print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:
☐ to improve my ability to work and function at home.
☐ to help my _____ (print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:
1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:
• I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
• I will not increase my medicine until I speak with my prescriber.
• My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
• I will keep all appointments set up by my prescriber.
• I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
• I agree to give a blood or urine sample, if asked, to test for drug or alcohol use.

Refills:

Refills will be made only during regular office hours—Monday through Friday, 9:00AM-6:00 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I will not come to Miracle Counseling for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy:
I will only use one pharmacy to get my medicine. My prescriber may talk with the pharmacist about my medicines. The name of my pharmacy is _____

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Prescriptions from Other Doctors:
If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a Doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to the prescriber in the original bottle, even if there are no pills left.

Privacy
While I am taking this medicine, my prescriber may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement:
If I break any of the rules, or if my prescriber decides that this medicine is hurting me more than helping me, this medicine may be stopped by my prescriber in a safe way.

I have talked about this agreement with my prescriber, and I understand the above rules.

Provider Responsibilities:
As your provider, I agree to perform regular checks to see how well the medicine is working.

Patient's Signature	Print Name	Date
First Prescriber's Signature	Print Name	Date
Second Prescriber's Signature (If necessary)	Print Name	Date

Clear fields | Save PDF | Print PDF | Email PDF