CONTROLLED SUBSTANCES AGREEMENT

I am a patient of **Dr. Remi Nader MD**, and I have been informed that individuals who are prescribed certain controlled substances including, but not limited to, narcotic pain medicines, stimulants, benzodiazepine tranquilizers, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the physician whose name appears below to consider prescribing or to continue prescribing controlled substances to treat my pain.

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
2. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substances will be prescribed to me. I agree that the need to be evaluated by psychologists and/or psychiatrists may be revisited every three (3) to six (6) months thereafter while taking the medication.
3. All controlled substances must come from a provider in **Dr. Nader**'s office. My controlled substances will come from the physician/ provider whose name appears below, or during his or her absence, by the covering physician, unless specific written authorization is obtained from the office for an exception.
4. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform **Dr. Nader**'s office.
5. I will inform **Dr. Nader**'s office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
6. I will inform my other health care providers that I am taking the controlled substances listed above, and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.
7. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
8. I will not allow anyone else to have, use sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is against the law.
9. I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
10. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
11. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
12. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.
13. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by **Dr. Nader** or a provider working in his office.
14. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes may develop.
15. I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication by **Dr. Nader' office**. Failure to comply may result in immediate discharge from the practice.
16. I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.
17. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report or a statement from me explaining the circumstances may be required before additional prescriptions are considered. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, I may be discharged from the practice.
18. I understand that a prescription may be given early if the physician/ provider or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.

19. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.
20. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.
21. I understand that I may be asked to bring my medications in their original container to the **Dr. Nader**'s office while I am on controlled medication.
22. Refills generally will not be given over the phone, after office hours, during the weekends, and on holidays.
23. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by my provider at **Dr. Nader**'s office.
24. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage.
25. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment, as well as possible discharge from the practice.
26. I agree that prescription renewals are contingent on keeping scheduled appointments. **I WILL NOT PHONE FOR PRESCRIPTIONS AFTER HOURS OR ON WEEKENDS.**
27. If I receive any controlled substances from a prescriber other than **Dr. Nader**, I will report that incident to my prescriber, in writing or have **Dr. Nader**'s office document it in writing in my chart, within 48 hours. Failure to do so may result in immediate discharge from the practice.
28. I acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to me and that I have had the opportunity to ask any questions that I may have.
29. I understand that controlled substances will be prescribed to me by **Dr. Nader** for a period of **NO LONGER THAN 3 MONTHS AFTER A SURGICAL PROCEDURE**. After this time, I will be referred to a pain management provider. There are no exceptions to this policy.
30. **I understand and agree that failure to adhere to these policies will be considered noncompliance and may result in cessation of controlled substance prescribing by my physician, possible dismissal from this clinic, and possibly being reported to the police or other law enforcement authorities.**
31. **I affirm that I have full right and power to sign and be bound by this agreement. I further affirm that I have been given the opportunity to ask any questions I may have and that I have read, understand, and accept all of its terms.**

_____
Patient Signature

_____
Patient Name (printed)

_____
Date

Physician Name: **Remi Nader MD**

URINE DRUG SCREEN TESTING
CONSENT FORM

AGREEMENT AND CONSENT TO
CONTROLLED AND/OR ILLICIT SUBSTANCE TESTING

I hereby agree, upon a request made under the controlled and illicit substance testing policy of Dr. Remi Nader, to submit to a urine drug screening test. I understand and agree that if I at any time refuse to submit to this testing under practice policy, or if I otherwise fail to cooperate with the testing procedures, I will not be issued any controlled prescriptions from Dr. Remi Nader. I further authorize and give full permission to have employees of Dr. Remi Nader send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to Dr. Remi Nader, his staff and assigned agents, and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize Dr. Remi Nader to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized officers, employees, and agents of Dr. Remi Nader will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make decisions regarding my treatment and medical care, and to respond to inquiries or notices from government entities when obligated by state and federal law to do so.

I will hold harmless Dr. Remi Nader, his employees, agents, and any testing laboratory he might use, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including cessation of prescription controlled substances for pain, refusal of another physician or provider to accept me as a patient, or any other kind of adverse action that may arise as a result of the urine drug test, even if a staff member or laboratory representative makes an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless Dr. Remi Nader, his staff and any assigned agents, and any testing laboratory the he might use for any alleged harm to me that might result from the release or use of information or documentation relating to the urine drug test, as long as the release or use of the information is within the scope of this policy and the procedures as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

I UNDERSTAND THAT DR NADER MAY REQUIRE A URINE DRUG SCREEN UNDER THIS POLICY WHENEVER I AM REQUESTING A NEW PRESCRIPTION AND/ OR REFILL FOR CONTROLLED SUBSTANCES, AND I AGREE TO SUBMIT TO ANY SUCH TEST.

_____
Signature of Patient

_____
Date