## Agreement for Controlled Substance Therapy

This agreement has been developed in the interest of promoting optimal drug therapy while minimizing risks to the patient, health care provider and society.

1. I, _____ agree that Dr. Brian Buggie will be the only physician prescribing _____.
I will obtain all of my prescriptions for this medication at one pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.

2. I understand the importance of taking the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of the medication without first discussing it with my physician. I understand that expected prescription refill dates will be used to promote optimal use of this medication.

3. My physician may require random urine testing as a matter of routine monitoring.

4. I will attend all reasonable appointments, treatments and consultations as requested by my physician. I will pursue other consultations/management strategies as necessary.

5. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.

6. I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my controlled substance therapy. I agree not to give or sell my prescribed medication to any other person. I acknowledge that my physician is not obligated to replace any medication shortfall.

7. I consent to open communication between my doctor and any other health care professionals involved in my management, such as pharmacists, other doctors, emergency departments, etc.

8. I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances for me.

Date: _____

_____    _____
(Patient Signature)                                        Brian Buggie, MD