# NYC Psychiatry & Primary Care Physicians

also DBA DOCTOR IN THE FAMILY formerly New York House Call Physicians

*Updated by Natan Schleider, M.D. February 5th, 2021*

Patient Name_____
Patient Date of Birth_____
Today's Date_____

## Controlled Medicine &/or Opiate Agreement

The purpose of this agreement is to prevent misunderstandings about certain controlled medications you will be taking. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.
_____ I understand that if I break this Agreement, my doctor will stop prescribing controlled medicines.
_____ In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.
_____ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to time when I am not driving, operating machinery and will be infrequent.
_____ I will not share my medication with anyone.
_____ I will not attempt to obtain any controlled medications, including opiod pain medications, controlled stimulants, or anti-anxiety medications from any other doctor.
_____ I will safeguard my medications from loss or theft. Lost or stolen medications will not be replaced.

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Patient Name_____

Patient Date of Birth_____

I agree to use the following pharmacy only:_____
Located at: _____,

_____ I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, primary care physician and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of controlled medication(s).

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused medicine to every office visit as the doctor's request.

_____ I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 20__.

Patient signature:_____

Physician signature:_____

Witnessed by:_____

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