MP VEERA MD PA
CONTROLLED MEDICATION AGREEMENT

130 PERPETUAL SQ. ANDERSON, SC 29621
864.224.8689 FAX 864.222-1303

The purpose of this agreement is to prevent misunderstandings about certain controlled substance medications, referred to as controlled medication, and to help both you and your provider comply with the state and federal laws regarding controlled medication. Because these medications have high potential for misuse, their administration is strictly controlled by local, state and federal governments. They include such classes of drugs as narcotics (for pain management, such as **OXYCONTIN, HYDROCODONE, CODEINE, and STADOL**), depressants (barbiturates), anti-anxiety medications (such as **XANAX and ATIVAN**), sedatives (such as **AMBIEN**) and stimulants (such as **ADDERALL**, **ADIPEX-P and DIDREX**). Their administration is intended to relieve, but not eliminate various symptoms, often pain; and is not simply to mask an underlying problem. Overdoses of controlled medications can cause serious illness or death.

Because your provider is prescribing a controlled medication for the management of your condition, you must agree to abide by the following guidelines. Please **initial beside each statement . Once read a full signature at bottom of page is required.**

_____ 1. I understand that I am responsible for my controlled medication. If the medication is lost, misplaced, or stolen, or if I do not follow the prescribed directions and I use all of the medication before I am eligible for a refill, I understand it will **not** be replaced.

_____ 2. I will not request or accept a controlled medication from any other physician or individual while I am receiving such medication from any of MP VEERA MD PA medical providers. Not only is it illegal to do so, but it may also endanger my health. The only exception is in the event that I am admitted to a hospital and a controlled medication is prescribed for me during my stay. (Please note that hospital admission does not include visits to an emergency department or an urgent care/minor care facility.)

_____ 3. Refills of my controlled medication:
   a. Will only be given during normal office hours. Refills will not be given at night, during office holidays or on weekends.
   b. Will not be given if I use all of the medication before I am eligible for a refill. I am responsible for taking my medication according to the prescribed directions, as well as for keeping track of the remaining amount.
   c. Will only be considered with at least seventy-two (72) hours advance notice. This holds true for requests submitted prior to the weekend.

_____ 4. I understand that if I violate any of the above conditions, my controlled medication prescription and/or treatment by MP VEERA MD PA providers may be terminated immediately. If the violation involves obtaining a controlled medication from another physician or individual, I may also be reported to the prescribing physician, corresponding medical facilities, and other necessary authorities.

_____ 5. I agree to abide by my physician's judgment regarding the necessity for controlled medication and the amount/frequency of medication that is best suited to the treatment plan as it is made, as well as when to cease the use of the medication.

_____ 6. I understand that if I am pregnant or become pregnant while taking controlled medication, my child could be physically dependent on the controlled medication and withdrawal can be life-threatening for the baby.

_____ 7. I understand that unannounced drug screens may be requested, and I will be in full cooperation with the administration of these tests.

_____ 8. I agree to fill all of my controlled substance prescriptions at the same pharmacy, and to provide my pharmacy information to MP VEERA MD PA. Any change of pharmacy will be promptly reported to the office.

_____ 9. I agree not to sell, lend or in any way give my controlled medication to any other person.

_____ 10. I understand that I will attend all required follow up visits with the physician to monitor the controlled medication and that failure to do so will result in discontinuation of this treatment.

_____ 11. I understand that there is a risk of addiction from controlled medications. This means that I might become psychologically dependent on the medication, using it to change my mood, get high, or be unable to control my use of it. People with a past history of alcohol or drug abuse are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment facility.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY | PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

_____ _____

SIGNATURE OF WITNESS | DATE

ISSUED 2/28/2012