Jeremy Laningham, M. D.
4015 I-45 North Ste 220
Conroe, Tx 77304

CONTROLLED SUBSTANCE MANAGEMENT AGREEMENT

Name_____Date_____

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management, anxiety, or ADHD. This is to help the patient and physician 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 these pain medications, anxiety medications, and ADHD medications.

_____In this case, my doctor will taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____I would also 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/anxiety, the effect of the pain/anxiety on my daily life, and how well the medicine is helping relieve my symptoms.

_____I will not use any illegal substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substance. 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.***

_____I agree that refills of my prescriptions for controlled substance will be made only at the time of an office visit. I will call and schedule appointment for refills before I am out of my medications. No refills will be available during evenings or on weekends.

_____I authorize my 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 controlled medications. I authorize my doctor to provide a copy of this agreement of my pharmacy, or local emergency room. I agree to waive applicable privilege or right to 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 pain, anxiety, or ADHD medications.

_____I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will results in my being without medicine for a period of time. ***There are no early refills of controlled substance.***

_____I agree to follow these guidelines that have been fully explained to me.

_____I agree to use_____for all controlled substance medications.
(Name of pharmacy)

Located at_____Pharmacy Number:_____

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient signature_____Date:_____

Witnessed by:_____Date:_____