Lemon-AID
Medical Management

CONTROLLED SUBSTANCE (SCHEDULE II-IV) PATIENT CONSENT FORM AND MANAGEMENT AGREEMENT

This Patient Consent Form and Management Agreement (the "Agreement") between -
_____("Patient") and Lemon-AID Medical Management ("Provider") sets forth the terms and conditions for the prescription and use of controlled substance medications longer than twenty-eight (28) days, including without limitation, narcotic analgesics, stimulants, benzodiazepines, and sedative-hypnotics (collectively referred to herein as "controlled substance medications") prescribed by the Provider for the Patient and is an essential factor in maintaining the trust and confidence necessary in a provider/patient relationship and to assure the patient's safety.

Effective Date of Agreement: _____

A. The Patient agrees to, accepts, and understands the following conditions as related to the use of controlled substance medications as prescribed by the Provider for the Patient, which are based on nationally recognized best practice guidelines:

1) This program's goals are to improve the Patient's medical condition and quality of life, and all recommendations relate to that.
2) The long-term benefits and risks of chronic controlled substance use are not fully established, and the medical evidence on long-term effectiveness remains limited.
3) Treatment recommendations and clinical best practice guidelines may change throughout treatment.
4) There are unknown risks associated with the long-term use of controlled substances, and the Provider may advise the Patient of knowledge and treatment advances and will make appropriate treatment changes.
5) There is a risk of an addictive disorder developing or a relapse occurring in a person with a prior addiction.
6) All controlled substance medications have potential side effects.
7) There are no refunds for medical services already provided. The Patient's financial obligation is to pay for medical consultation services rendered in the Provider's best judgment. Payment is for the consultation, not for the ability to fill a prescription or for receipt of any particular medication.

B. The Patient must notify the Provider immediately if the Patient is pregnant, may become pregnant, is planning to become pregnant, or is breastfeeding, because controlled substance

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medications may cause harm to a fetus or nursing infant. Upon such notice, the Provider will reassess the Patient's treatment plan, which may result in a change to or discontinuation of the Patient's controlled substance medications.

C. The Patient agrees to take the medication only as the Provider prescribes, by the route and in the form prescribed. If the Patient uses more than the prescribed amount, alters the form or route of administration, shares or provides the medication to any other person, or combines it with non-prescribed controlled substances or illicit drugs, the Provider may terminate this Agreement immediately.

D. ***Patient Responsibilities.*** The Patient agrees to accept the following responsibilities:

1) Driving or operating machinery while taking controlled substances may have untoward consequences, and the risk is greatest when treatment begins and after any dose change. I understand the Provider may advise me not to drive or operate machinery during those periods. If I elect to drive or operate machinery or equipment, I do so at my own risk.
2) I will not use illicit drugs or alcohol or misuse drugs in combination with my controlled substance.
3) I understand it is illegal to give or sell controlled substances to others.
4) The undersigned Provider will be the primary prescriber for my controlled substance medication. I understand that controlled substances are prescribed at the prescriber's discretion and within the scope of their practice. I will not seek to have duplicate prescriptions for my controlled substance medications. I understand that if it is discovered that I have received duplicate prescriptions for controlled substances from any other provider, Lemon-AID Medical Management may immediately discontinue medication prescribing and notify pharmacies and other treating physicians.
5) I understand that my primary prescriber will not provide opioids for acute pain arising post-operatively or from an acute injury. I understand my treating surgeon or provider for the acute injury will handle this. I understand I must contact my primary prescriber within twenty-four (24) hours to notify them of any opioid medication that an outside provider prescribes.
6) I will safeguard my controlled substance medication from loss or theft and safely dispose of expired, unused, or unwanted controlled substances through community take-back programs, local pharmacies, or local law enforcement agencies.
7) If naloxone is prescribed by my Provider, I understand I must fill the prescription at a pharmacy and keep it accessible for emergency use.
8) I understand that lost, stolen, damaged, or destroyed medication will not ordinarily be replaced, and that no prescription will be refilled early on that basis. I understand that I may

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be required to attend more frequent office visits until my next scheduled visit, or I may not receive medication until that visit. I will report any theft to law enforcement and provide a copy of the report to the Provider upon request.

Patient Initials: _____ Date: _____

E. ***Pharmacy and Information Sharing.*** The Patient must obtain all controlled substance medications prescribed from the same pharmacy listed below.

Pharmacy Name	
Phone	
Address	

1) If the Patient needs to change the pharmacy named above for any reason, the Patient is required to immediately notify the Provider so that this Agreement can be modified with the new chosen pharmacy.
2) In the event of a bona fide emergency or unavoidable travel that makes use of the named pharmacy impracticable, the Patient may fill a prescription elsewhere, provided the Patient notifies the Provider as soon as practicable and in no event later than the next business day.
3) The Patient grants the Provider express permission and consent to discuss all diagnostic and treatment details with the dispensing pharmacy or other health care professionals involved in the Patient's care.
4) The Patient acknowledges and consents to the Provider reviewing the Patient's prescription history through the state Prescription Drug Monitoring Program (PDMP) or any equivalent prescription monitoring database at any time during treatment.

F. ***Controlled Substance Medication Prescription Refills.*** The Patient agrees to the following:

1) I will receive prescription refills for my controlled substance medication only during regular office hours. Refills will not be made after hours, and no refills will be made without a visit.
2) No controlled substance prescriptions will be refilled early, except as expressly provided in this Agreement or as determined by the Provider in the Provider's sole discretion.
3) I will call at least seventy-two (72) hours in advance if I need a prescription refill. I understand that I will not be able to get my monthly prescription if I do not make and attend the required appointments. I will keep my appointments with Lemon-AID Medical Management and call at least twenty-four (24) hours in advance to cancel appointments

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and reschedule before the next refill is due.

G. ***Continuing Evaluation.*** The Patient is required to submit to random blood or urine testing, and to random counts or inspection of remaining medication, as requested by the Provider to determine compliance with this Agreement and to keep the treatment regimen as safe as possible. Failure to comply with the guidelines set forth in this Agreement, refusal or failure to submit to testing when requested, or any attempt to tamper with, adulterate, dilute, or substitute a sample, may result in the Patient not receiving a prescription or receiving a limited quantity of medication at the Provider's discretion, and may result in termination of the Provider-Patient relationship.

H. ***Consequences of Noncompliance.*** Provider and Patient agree that this Agreement is essential to the Provider's ability to treat the Patient's medical conditions effectively. If the Patient fails to abide by all terms of this Agreement, the Provider may withdraw all controlled substance medications prescribed by the Provider, terminate this Agreement, and terminate the Provider-Patient relationship and ongoing services.

I. If controlled substance medications are discontinued or this Agreement is terminated, the Patient may be provided with a short-term taper, depending on the Patient's individual circumstances and the Provider's clinical judgment. The Provider may also refer the Patient for continued care. Nothing in this Agreement obligates the Provider to continue prescribing controlled substance medications or to provide a taper of any duration.

J. ***Term and Renewal.*** This Agreement takes effect on the Effective Date and remains in effect until terminated. The Provider may require the Patient to review and re-sign this Agreement annually, or whenever the Patient's treatment plan or medication regimen materially changes. The Provider may amend this Agreement upon written notice to the Patient.

Acknowledgment. I have read this Agreement, or it has been read to me. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand and voluntarily agree to its terms, and I acknowledge that I have received a copy of this Agreement.

	Printed Name	Signature	Date
Provider	_____	_____	_____
Patient	_____	_____	_____
Patient Legal Guardian (if applicable)	_____	_____	_____

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