CAPSTONE
Family Practice

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MEDICATION AGREEMENT

I WILL NOT:

I will not see any other physician for my medication while under the care of this group. All my medication from this clinic cannot be obtained from any other source. In the event of an acute case (dental work or surgical procedure), I must notify my physician in advance.

I will not use alcohol or illegal controlled substances (cocaine, marijuana, etc.). I have been made aware of the dangerous side effects of medication use alone or in combination with other substances. Thus, I absolve the physicians and staff of any willful negligence.

I will not share, sell or trade my medication(s) or prescription(s) with anyone.

I will not attempt to obtain any controlled medicines, including opiod pain medicines, controlled stimulants, or anti-anxiety medications from any other doctor(s) unless approved by my physician in advance.

I WILL:

I will provide the physician and staff with all my medical records pertaining to my past pain treatment. I understand that failure to provide such information gives the clinic the right to refuse to treat me.

I will be responsible for my medicine, keeping it safe from loss or theft. Lost medications will NOT be replaced. Stolen medication will not be considered for refill until a police report is filed and sent to the doctor's attention.

I will use my medicines at the rate they are prescribed. If I use my medicines at a greater rate, it will result in my being without medication for a period of time. Physicians will NOT authorize any early refills under any circumstance.

I will only use one pharmacy to fill all my prescriptions. I agree to use _____ Pharmacy,

located at _____ Telephone number: _____ for filling prescriptions for all my controlled medications. If I need to change for any reason, I will notify Capstone Family Practice in writing.

I will agree that no refills will be available during evenings or weekends.

I will agree to authorize the doctor and the 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 or sale, etc., of my medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.

I will submit to a blood or urine test if requested by my doctor.

I understand all the policies above and my signature below states my agreement to comply. I am aware that if I breach this agreement, then Capstone Family Practice holds the absolute right to discharge me as a patient.

Signature_____ **Date:**_____