PROMISECARE
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Jorge Martinez, M.D.
29826 Haun Road, Suite 201 Menifee, CA 92586
(951) 301-1100
https://drmartinez.health/

Controlled Substance Agreement

I, ____________________________, understand and voluntarily agree to the following:

_____ I will keep (and be on time for) all my scheduled appointments with the provider or other members of the treatment team.

_____ I will participate in all other types of treatment that are ordered for my care and treatment. This may include physical therapy, radiological studies, or psychotherapy.

_____ I will keep my medications safe, secure, and out of the reach of children. If the medication is lost or stolen, I understand it will not be refilled early and may not be refilled at all.

_____ I will take my medication as instructed and not change the way I take it unless discussing the change with my provider or a member of the treatment team.

_____ I will not call between appointments, after hours or on weekends requesting refills. I will not request that the pharmacy contact the provider for refills. I understand that prescriptions will be filled only during scheduled office hours.

_____ I will make sure I have an appointment for refills. I understand appointments for refills will not be same day urgent appointments.

_____ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to the staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell or share my medication with others. I understand if I do, my treatment will be stopped.

_____ I will sign a release form to let the provider speak to all other providers that I see.

_____ I will tell the doctor all other medications or supplements that I take and call the office right away if I have a prescription for a new medication to avoid any drug interactions.

_____ I will use only one pharmacy for my controlled medications:

Pharmacy name: _______________________________

_____ I will not get any opioid pain medicines or other medicines that can be addictive, such as benzodiazepines (Klonopin, Xanax, Valium, Ativan) or stimulants (Ritalin, Adderall, Amphetamine) without calling the provider before I fill that prescription. I understand that the use of any controlled medication not prescribed under this contract may result in termination of care.

_____ I have been advised that taking a combination of opioids and benzodiazepines puts me at risk for negative consequences such as: higher risk of overdose and death, higher risk of suicide, and worse treatment outcomes. I will work with my provider to decrease and taper my benzodiazepine use and transition to a safer medication as deemed appropriate.

_____ I will not use illegal drugs such as heroin, cocaine, methamphetamines, or others. I understand that if I do, my treatment will be stopped, and I will be referred for substance abuse treatment.

_____ I will comply with all drug testing and pill counting as requested and within 24 hours of the request. I understand that I must keep the office current with my contact information. I agree to pay all costs associated with the drug testing that is not covered by my insurance.

_____ I will alert the office immediately if I lose my insurance. I understand the office does not allow cash visits for controlled substances.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

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We here at (Office Name/PromiseCare) are making a commitment to work with you in your effort to get better and maintain a reasonable quality of life.

To help you achieve this, we agree that:

We will help you schedule regular appointments for medicine refills. If we must cancel or reschedule your appointment for any reason, we will make sure you have enough medication to last until your appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not experiencing bad side-effects. If we determine that the risk of medications outweighs the benefit, we will taper in a safe manner or refer for treatment that may be safer and/or more effective.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored.

We will refer you to other forms of treatment, if needed to help you with your condition.

We will work with any other providers you are seeing to assure you are being treated safely and effectively.

If you become addicted to these medications and exhibit signs and symptoms of substance abuse, we will help you get treatment and off the medications safely.

______________________________	______________________________	______________________
Patient signature/DOB	Patient printed name	Date
______________________________	______________________________	______________________
Provider signature	Provider printed name	Date

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