Wesley
Neurology Clinic

Patient Agreement for the Prescription of Controlled Substances

The purpose of this Patient Agreement for the Prescription of Controlled Substances ("Agreement") is to prevent misunderstandings about medicines that you will be taking for pain management, and insure that you and your physician comply with all laws regarding the prescription and use of 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; and, that if I break this agreement, my doctor may stop prescribing pain-control medicines for me and may terminate me from further treatment at Wesley Neurology Clinic or by any other physician employed at Wesley Neurology Clinic.

I agree to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

Females only – I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my doctor if I believe I may be pregnant. I agree not to take any medication without a physician's approval if I become pregnant.

I will not use any illegal controlled substances (including marijuana, cocaine, or heroin), unless prescribed by my physician.

I will not share, sell, or trade my medications with anyone. I will bring all unused pain medication to every visit.

I will not attempt to obtain controlled medicines, stimulants, or anti-anxiety medicines from anyone else.

I will safeguard my medicine. No allowance will be made for lost or stolen medicine or prescriptions.

I agree that refills of my prescriptions for pain medicines should be obtained only during routine office visits. It is understood that emergency refill requests may only be obtained during regular office hours (8:30 to 4:30 M-F). NO refills will be available after hours, on weekends or holidays.

I agree to use **ONLY** the following pharmacy for filling prescriptions of all controlled substances:

Pharmacy Name	**Address**	**Phone Number**

I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or the board of pharmacy in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that if it is required to determine my compliance with the pain management program and this agreement, I will submit to random drug testing, at my expense.

I agree that I will use my medicine at a rate no greater than the prescribed rate and I understand that the use of my medicine in a greater rate may result in my death.

I attest that the above guidelines have been fully explained to me and that my questions and concerns regarding my treatments have been adequately answered. I have been given a copy of this agreement.

This agreement is entered into on (date): _____

Patient Signature: _____

Physician Signature: _____

Central Office: 1211 Union Ave, Suite 400, Memphis, TN 38104
North Office: 3950 New Covington Pike, Suite 270, Memphis, TN 38128
East Office: 8000 Centerview Parkway, Suite 305, Cordova, TN 38018