McCormick Family Dentistry

CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

Depending on your specific care needs, your provider may prescribe you something that is deemed a controlled substance. To adequately care for you, the patient, please review the following agreement and sign. Failure to do so will prohibit you from receiving the medication you may need.

- This Agreement is essential to the trust and confidence necessary in a provider/patient relationship.
- If I break this Agreement, my provider will stop prescribing me controlled substances.
- I will communicate fully with my provider regarding all medications I am taking, over the counter or prescribed. I understand that certain medications may have an adverse effect; therefore, my provider must be made aware.
- I will not share my medication with anyone.
- While being treated by Dr.McCormick, I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider. If necessary to do so, I will communicate immediately with my provider.
- I will safeguard my medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.
- I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period.
- I understand that my provider might be verifying that I am receiving controlled substances from only one prescriber by checking the Mississippi Prescription Monitoring Program web site periodically throughout my treatment period.
- This agreement will remain in my administrative file and will be updated annually.

I agree to follow these guidelines that have been presented to me. ________**(Initial here)**

This Agreement is entered on this _____ day of__________, _____ .

Patient Signature: ____

Patient Name (printed): ____

Witnessed by: ____

Effective Date: 10/16/2017