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

This Patient Consent Form and Management Agreement (the "Agreement") between ("Patient") and ("Provider") sets forth the terms and conditions for the prescription and use of controlled substance medications longer than thirty (30) days, including without limitation, narcotic analgesics, benzodiazepine tranquilizers, non-benzodiazepine hypnotics, and barbiturate sedatives (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.

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. The improvement of the Patient's medical condition and quality of life are the goals of this program and all recommendations relate to that.
    2. The long-term advantages and disadvantages of chronic use of controlled substance medication is controversial and without an ultimate scientific / clinical determination as its effectiveness.
    3. Treatment recommendations and clinical best practice guidelines may change throughout the Patient's course of treatment.
    4. There are unknown risks associated with the long-term use of controlled substances and the Provider may advise me as knowledge and training advances and will make appropriate treatment changes.
    5. There is also the risk of an addictive disorder developing or a relapse occurring in a person with a prior addiction. The extent of this risk is uncertain.
    6. All controlled substance medications have potential side effects. Unfortunately, some patients do experience side effects that force the termination of the medication(s) being used. Common side effects in general can include but not limited to constipation, itching, nausea, vomiting, sedation, and or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing, mental slowing, loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone). For Stimulants: increase heart rate and blood pressure, worsening of symptoms in patients with bipolar disorder and psychosis, appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, and difficulty sleeping. For Benzodiazepines: Drowsiness, fatigue, sedation, loss of coordination, memory impairment, irritability, cognitive dysfunction, difficulty speaking, dizziness, depression, weight gain, weight loss, decreased sex drive, increased appetite, decreased appetite, constipation, dry mouth, difficulty with urination.
    7. All narcotic prescriptions must be obtained from a GRACE AT HOME practitioner. If a new condition develops, such as trauma or surgery, then the physician caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify GRACEAT HOME within 48 hours of my receiving a narcotic or any other controlled substance from any other provider. Failure

to notify Grace At Home or filling of a narcotic prescription from a non-Grace At Home provider will void this contract and be grounds for Grace At Home no longer prescribing any narcotics. For females only: if I become pregnant while taking this mediation, I will immediately inform my obstetrician and obtain counseling on risks to the baby.

8. I will submit urine, saliva and/or blood on request for testing at any time without prior notification to detect the use of non-prescribed drugs/medications and confirm the use of prescribed ones. I understand I may be responsible for the cost of these tests
9. Requests for refills on Narcotics must be made by discussion with the Provider at time of visit or by contacting GRACE AT HOME during business hours and at least three workdays in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy. I choose to utilize _____ pharmacy and will notify GRACEAT HOME immediately of a pharmacy change.
10. I authorized my pharmacy to release a record of my medications to the office upon request. A copy of this contract may be sent to my pharmacy.
11. The daily dose may not be changed without my GRACE AT HOME physician or practitioner's consent. Taking more medication than is prescribed will NOT result in an early refill or change to a different medication before the next scheduled fill date. The Patient agrees to take the medication only as prescribed by the Provider. Use of increased amount of controlled substance medication than prescribed is a dangerous situation could result such as coma, organ damage, or even death. If Patient uses more than the prescribed amount of controlled substance medication, the Provider may terminate this Agreement immediately.
12. Prescription refills will not be given prior to the planned refill date determined by the dose and quantity prescribed. I will accept generic medications.
13. Accidental destruction, loss of medications or prescriptions will NOT be a reason to refill medications or rewrite prescription early. I will safeguard my narcotic medications from use by family members, children or other unauthorized persons. I will not sell medication prescribed to me. I will not give this medication to others. I will keep this medication in a locked container when possible.
14. I understand narcotic/controlled substances have addictive potential and that my physician/Provider may place me on a tapering regimen at his/her sole discretion in attempts to achieve the ultimate goal of discontinuation of its use.
15. I understand that GRACE AT HOME providers are practicing primary care and NOT pain management. GRACE AT HOME Providers will not be able to prescribe chronic pain medication in doses exceeding 60-90 morphine equivalents per day. Quantities above this amount will require referral to pain management.
16. GRACE AT HOME providers will make ONE referral to a pain clinic. Patients who are denied services or discharged from pain management will be required to find an alternative pain management

specialist independently. We are happy to send records to additional pain management doctors once notified by patient.

B. The Patient agrees to accept the following responsibilities:
   1. I agree that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform any activity until my ability to perform the activity has been evaluated or I have not used my controlled substance medication for at least four days.
   2. I will not use any illegal substances. I will use alcohol minimally/in moderation or not at all with my controlled substance medication. I understand that I can create a dangerous situation by using alcohol with my controlled substance medication. While cannabis (CBD/THC) containing products may be legal in my State of residence, I am aware that using these products with my controlled substance medication may create a dangerous situation. I will make my Provider/Pharmacist aware if I use alcohol or cannabis, regardless of how much or how often I use them.
   3. I will not share, sell, or trade my controlled substance medication for money, goods or services. I understand that it is against the law to do so.
   4. I will not attempt to get any controlled substance medications from any other health care provider without telling them that I am taking controlled substance medication prescribed under this Agreement. If another health care provider prescribes Patient a different controlled substance medication, I will immediately notify Provider.
   5. I will discontinue all previously used controlled substance medications, unless told to continue by my provider.

C. Pharmacy
   1. I will safely dispose of expired, unused, or unwanted controlled substances through community take-back programs, local pharmacies, or local law enforcement agencies. For more information on the safe disposal of prescribed controlled substances, please visit: https://www.fda.gov/drugs/disposal-unused-medicines- what-you-should-know/drug-disposal-drug-take-back-locations.
   2. All controlled substance medications prescribed to Patient must be obtained at the same pharmacy as set forth below.

Pharmacy Name: **Address:** **Phone:**

   3. 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.
   4. Provider has express permission, and Patient grants consent to discuss all diagnostic and treatment details with the dispensing pharmacy or other health care professionals involved in Patient's care. Patient agrees to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of controlled substance medication and authorizes Provider and pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State Board of

Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled substance medication. Patient authorizes Provider to provide a copy of this Agreement to my pharmacy.

D. Patient agrees to the following regarding Controlled Substance Medication Prescription Refills:
   1. Prescription refills of my controlled substance medication will be made only during regular office hours. Refills will not be made after hours. No refills will be made over the telephone.
   2. No controlled substance prescriptions will be refilled early for any reason, including lost, stolen, or destroyed medication.
   3. I will call at least 72 hours in advance if I need a prescription refill. I understand that unless a longer interval is allowed by State law, I am required to be seen for re- evaluation every month to assess and optimize treatment goals

E. Continuing Evaluation:
   1. While not required for every patient, patient agrees to be evaluated by a specialist including but not limited to a psychiatrist, psychologist, clinical pharmacist, pain management specialist, or addiction specialist ("Specialist") at any time during treatment as requested by the Provider.
   2. Every effort will be made to wean Patient completely off, or to the minimal possible dose, of controlled substance medication through use of other treatments that can help treat the underlying condition, or as the underlying condition self-resolves.

F. Telemedicine:
   1. I understand that my provider must abide by federal and state laws restricting controlled substance prescribing via telemedicine.
   2. Should federal or state law prohibit my provider from prescribing controlled substances through telemedicine, I understand that an in-person appointment will be required before I am prescribed a controlled substance(s).

Provider and Patient agree that this Agreement is essential to the Provider's ability to treat the Patient's medical conditions effectively in a patient centric approach and that failure of the Patient to abide by all of the terms of this Agreement may result in the withdrawal of all controlled substance medication prescribed by the Provider and the subsequent termination of this Agreement which may lead to the termination of the Provider- Patient relationship and ongoing services.

Patient Name (printed)	Provider Name (printed)
Patient/POA/Legal Guardian Signature	Provider Signature
Date	Date