Corewell Health™

Dear Patient,

To ensure the quality and safety of our plan of care, you agree to use the scheduled prescriptions prescribed by me without any abuse. I will perform a **Michigan Automated Prescription System (MAPS)** report to monitor your safe use of controlled prescriptions.

Controlled substances include narcotics (opioids), stimulants barbiturates and benzodiazepines (tranquilizers). If you have been prescribed controlled substances for pain management, please understand that this is a short-term treatment based on improvements in functioning. Controlled substances may make your symptoms tolerable but may not resolve them entirely. I will not prescribe a controlled substance for anxiety or ADD if you are already on an opioid medication.

You agree to participate in all parts of the prescribed treatment plan which may include but is not limited to psychotherapy and regularly scheduled office visits. I am under no obligation to provide controlled substances, and you reserve the right to discontinue any controlled substance at any time. You agree to a urine / blood drug screen prior to having any controlled substances prescribed. This test may or may not be covered by your insurance.

You understand that controlled substances will only be prescribed by me according to an agreed-upon schedule. Prescriptions will be provided during normal office hours; they will not be mailed, faxed, or called-in to your pharmacy. I have two (2) business days to respond to your refill requests. It is your responsibility to anticipate the need for refills and to plan accordingly. No controlled substance will be refilled early unless I adjust its dose or frequency. You understand that overused, lost, stolen, or damaged controlled substances will not be refilled early, under any circumstance. If you are non-compliant with your appointments, your medications may not be refilled. Two (2) consecutive no-show or canceled appointments may constitute grounds for immediate termination of this agreement.

I may request random urine screens to ensure you have not been taking any illicit substances that violate your treatment plan with me. If you refuse these screens, your controlled substances will be discontinued. If I am convinced that you have been taking controlled substances from other providers while being in treatment with us, or that you have been refilling them earlier than recommended, we will be terminating your treatment with us. We will provide you with names of organizations that can provide care for you. You may visit our ER if there is an emergency.

Thank you for your cooperation.

_____	_____
Patient Printed Name Date	**Patient Signature Date**
_____	_____
Witness Signature Date	**Provider Signature Date**