

Controlled Substance Usage Monitoring Agreement

Date: _____

Patient Name: _____

Patient ID: _____

Agreement Overview

This agreement governs the use of controlled substances prescribed for medical purposes. By signing this document, you agree to adhere to the terms outlined below.

Terms and Conditions

1. I understand that the use of controlled substances is for medical treatment only.
2. I agree to take medications as prescribed and will not share my medication with others.
3. I will not seek controlled substances from any other healthcare provider without informing my primary physician.
4. I consent to random drug testing as required by my healthcare provider.
5. I understand that violation of this agreement may result in termination of treatment.

Patient Acknowledgment

By signing below, I acknowledge that I have read and understood the terms of this agreement and agree to comply with the conditions set forth.

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____