# Porter Medical Associates

## ***INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT***

PATIENT NAME: _____ DOB: _____ DATE: _____

**TO THE PATIENT:** As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician, but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

**CONSENT TO TREATMENT AND/OR DRUG THERAPY:** I voluntarily request my physician, **Carlos Porter, MD,** to treat my condition which has been explained to me. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element for treatment. It has been explained to me that these medication(s) include opioid/narcotic drug(s), stimulants, sedatives, etc., can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may; like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions and that death is also a possibility as a result from taking these medication(s).

The specific medication(s) that my physician plans to prescribe will be described and documented separate from this agreement. This includes the use of medications for purposes different than what has been approved by the drug company and the government *(This is often referred to as "off-label" prescribing)*. My doctor will explain his treatment plan(s) and document them in my medical chart.

**I HAVE BEEN INFORMED AND UNDERSTAND** that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary. I hereby give permission to perform the tests; **my refusal may lead to termination of treatment.** The presence of unauthorized substances, or substances still considered by the State of Texas to be illegal, may result in my being discharged from my physician's care.

I understand that the goal of this treatment is to help me gain control of my medical condition in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) the symptoms of my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolong or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication(s) use.

**I understand that the most common side effects that could occur in the use of the medication prescribed to me for my treatment INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING**: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, intolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate automobiles or other machinery while using these medications and I may be impaired during all activities, including work. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for treatment.

I understand that NO WARRANTY OR GUARANTEE has been made to me as to the results of any drug therapy, or cure of any condition. The long-term use of medications is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment. The risks of non-treatment, and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s) have been explained. I believe that I have sufficient information to give this informed consent.

**_____ Initials**

***FOR FEMALE PATIENTS ONLY:***

- *To the best of my knowledge* ***I am NOT pregnant.*** *I will use appropriate contraception/birth control during my course of treatment. I accept that it is* ***MY responsibility*** *to inform my physician immediately if I become pregnant.* ***If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.***
- *All of the above possible effect of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics/stimulants to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.*

**_____ Initials**

**I UNDERSTAND AND AGREE TO ALL OF THE FOLLOWING:**

I have been notified the long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives, and other controlled medications are controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. My physician may at any time choose to discontinue the medication(s). **Therefore, medication(s) will only be provided so long as I follow all of the rules specified in this Agreement. Failure to comply with *any* of the following guidelines and/or conditions will be cause discontinuation of medication(s)**, and/or my discharge from care. Discharge may be immediate for any criminal behavior:

- I will notify my physician **all medication(s)** that I take at any time, prescribed by any physician. **_____ Initials**
- All medication(s) must be obtained at **one pharmacy where possible. _____ Initials**
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- Should the need arise to change pharmacies, I will notify my physician. **_____ Initials**
- All controlled substances must come from Porter Medical Associates physicians, unless specific authorization is obtained for an exception. I am aware that this is for my safety and wellbeing, and information that I have been receiving medication(s) prescribed by other doctors not approved by my physician may lead to a discontinuation of treatment **_____ Initials**
- I will inform my physician of any new medications, or medical conditions, and/or any adverse effects I experience from any of the medications that I take. **_____ Initials**
- I will not share, sell, or otherwise permit others to have access to these medications. **_____ Initials**
- I understand that my medication(s) will be refilled at my scheduled monthly appointment. **_____ Initials**
- I understand that my prescription(s) are like money; **if my medication(s) is destroyed, lost, or stolen. THEY WILL NOT BE REPLACED. _____ Initials**
- **Refill(s) will NOT be written before the scheduled refill date or outside of scheduled appointments.** I will not expect to receive prescriptions prior to the time of my next scheduled refill, even if my prescription(s) run out. In case of travel only: Arrangements may be made in person with my physician, in advance of the planned departure date, at my scheduled appointment. I am aware that controlled medications will **NOT** be called in. **_____ Initials**

- Refills are given ONLY at scheduled appointments. **I will not call after hours or on weekends.** _____ **Initials**

- If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substance administration. _____ **Initials**

- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s). _____ **Initials**

- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time, and without prior warning, at my own cost, regardless of what insurance I have. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment will be terminated, and I may be discharged from care. A consult with/referral to an expert may be necessary for psychiatric or psychological evaluation by a qualified physician, such as an addictionology specialist, or physician who specializes in detoxification and rehabilitation, and/or cognitive behavioral therapy/psychotherapy. _____ **Initials**

- Prescriptions and bottles of medication(s) may be sought by other individuals with chemical dependency and should be closely safeguarded. I am aware that it is expected that I will take the highest possible degree of care with my medication(s) and prescription(s) and know that they **WILL NOT BE REPLACED.** _____ **Initials**

- Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, medication(s)/prescription(s) will not be left where others might see or otherwise have access to. _____ **Initials**

- The prescribing physician has permission to discuss all diagnostic and medical conditions, and or any adverse effects you experience from any of the medication(s) that you take with dispensing pharmacists or other professionals who provide your health care for purpose of maintaining accountability. _____ **Initials**

- Original container(s) of medication(s) should be brought into each office visit. _____ **Initials**

- I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment. _____ **Initials**

- I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, stimulants, or painkillers) or substances illegal in the State of Texas (marijuana, cocaine, heroin, etc.) _____ **Initials**

- **I am aware failure to comply with guidelines, afore mentioned, can lead to termination of care, regardless of insurance coverage, third (3rd) party involvement, or governing body.** _____ **Initials**

- **I am aware that this document supersedes any other.** _____ **Initials**

**No guarantee or assurance has been made** as to results that may be obtained from treatment. With full knowledge of the potential benefits, and possible risks involved, I consent to treatment, hoping for the opportunity for a more productive and active life.

## ***Patient Appointed Pharmacy:***

The pharmacy I have selected to use is:

**NAME**: _____

**PHONE:** _____ **FAX:** _____

**ADDRESS:** _____

_____ _____ **Initials**

**(EXACT ADDRESS IS REQUIRED; CROSS STREETS ARE NOT VALID)**

**I affirm that I have full right, and the power to sign and be bound by this agreement. I have read, understand, and accept all of its terms.**

_____ _____
Patient Full Name (PRINTED) Date

_____ _____
Patients Signature Date

_____ _____
Witness Signature Date

_____ _____
Physician Signature Date