Family First Medicine, APMC
902 S. Vienna Street
Ruston, Louisiana 71270

Patient Treatment Contract

As a participant in thecontrolled substances program, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep, and be on time to, all my scheduled appointments. This includes counseling appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit will result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree to make another appointment in case of a lost prescription or stolen medication.
9. I agree to store medication properly. Medication may be harmful to children, household members, guests, and pets. The Medication should be stored in a safe place, out of the reach of children. If anyone besides the patients ingests the medication, I agree to call the Poison Control Center or 911 immediately.
10. I agree not to obtain any controlled medications from any doctors, pharmacies, or other sources without telling my treating physician.
11. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous.
12. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.
13. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
14. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
15. I agree to notify the clinic in case of abuse of medication. An appropriate treatment plan must be developed as soon as possible.
16. I agree to the guidelines of office operations. I understand the procedure for making appointments. I do have the phone number of this clinic and I understand the office hours.
17. I understand that no medications will be prescribed by phone or on weekends.
18. I agree to comply with the required urine tests. Urine testing is a mandatory part of office maintenance. The patient must be prepared to give a urine sample for testing at each clinic visit.
19. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).
20. I agree to allow my doctor to test my blood alcohol level.
21. I understand that violations of the above may be grounds for termination of treatment.
22. I understand that the phone numbers I give will be used to contact me and that any phone number change will immediately be given to my Physician's office. I also give my permission for messages to be left on said phone number(s) voice mail or person answering the call to have you return our call if a message needs to be left. NO DETAILED MESSAGES WILL BE LEFT WITH THE PERSON OR PERSONS TAKING THE MESSAGE

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Signature Date