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**Long-term Controlled Substances Therapy Agreement for Chronic Pain**

This is an agreement between (patient name):

and , MD regarding the diagnosis of:

for which the following medication(s) have been prescribed (narcotics or other controlled substances):

I understand that there are alternative treatments which include: physical therapy, topical analgesics, acetaminophen, non-steroidal anti-inflammatory drugs, ultram or tramadol, acupuncture and other modalities.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a narcotic increases certain risks. I have reviewed and signed the Controlled Substances Consent Form which describes these risks in detail.

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from physician whose name appears on this agreement. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed.

2. I understand that due to the high potential for risks and/or abuse of these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of damaged, lost or stolen medication. Refills will be provided at scheduled appointments.

3. I will obtain ALL of my controlled substance prescriptions from Dr. or, during physician’s absence, by the on-call physician, unless specific authorization is obtained for an exception.

4. I will fill ALL of my controlled substance prescriptions at (*pharmacy name/phone)*:

Should the need arise to change pharmacy, I will notify physician whose name appears on this agreement, as soon as possible.

5. I will submit to urine or blood tests if requested to assess my compliance.

6. I agree to keep regularly scheduled appointments as long as I am taking narcotic medication. I will tell Dr. about all other medications and treatments that I am receiving.

7. If I do not follow these guidelines, I understand that my treatment may be terminated.

I have discussed the risks, benefits and alternatives to narcotic treatment with Dr. . I have had an opportunity to ask questions and receive answers to those questions to my satisfaction. I have read, understand and accept the terms of this agreement.

Patient

Signature: Date:

Physician

Signature: Date:

SAACC Form: Controlled Substances Agreement