

Dynamic Health Associates, P.A.
5015 Manatee Ave W, Suite 107
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www.DynamicHealthBradenton.com

PATIENT CONSENT TO MEDICATION MANAGEMENT and PRESCRIBED CONTROLLED SUBSTANCES

The following agreement relates to my use of controlled substances prescribed by physicians of Dynamic Health Associates, P.A. This agreement is according to Florida statute CS/CS/HB 7095 3rd Engrossed/Enrolled-Prescription Drugs, effective July 1, 2011.

I recognize that these are policies regarding the use of controlled substances that are followed by the staff. I will be provided controlled substances while actively participating in my treatment plan **ONLY** if I adhere to the following regulations:

Rx Prescription Refill Policies

- No prescriptions will be refilled on Saturdays, Sundays or Holidays.
 - Require **3 business days** minimum to process prescription(s) renewal and/or pick-up requests.
 - The patient is responsible for knowing when medication(s) will need to be refilled (no early refills).
 - Prescription phone-in/pick-up: Monday-Friday during business hours **ONLY** (9am-4:00pm).
 - Prescriptions will not be filled for “walk-in” patients.
 - Non-controlled/non-narcotic prescriptions require a follow up appointment every **3-6 months**.
 - Controlled-substances/narcotic prescriptions require a follow up appointment every **30-90 days**.
 - New symptoms and/or events require a clinic appointment. Doctor unable to diagnose via phone.
 - Signed “Controlled-Substance/Narcotic Policy” required if using narcotic/controlled medications.
 - No early refills if medications are overused/abused/misused. Must follow prescription directions.
 - No medication/prescription will be replaced if lost, stolen, misplaced, overused, etc. ***Treat like money.***
 - Medications are for the prescribed individual’s use only. It is illegal to “share” your medicine.
 - Patient must pick-up his/her prescription(s) in person, unless pre-authorized by staff.
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- I will notify my treating and/or prescribing Dynamic Health Associates, P.A. physician of any change in my medical condition, including pregnancy for females.
 - I will take any and all prescribed medications only as directed by my physician or authorized associate. I will not obtain pain medications from more than one physician, request early refills, or request replacement of lost or stolen medications or prescriptions.
 - I will NOT request refills after hours, on weekends, or on holidays.
 - I will fully read the packet inserts of prescribed medications, in order to fully understand the risks and benefits of each prescribed medication, I will present any questions or concerns that may arise after reading the inserts to my physician.
 - I will submit to random urine or blood prescription monitoring testing to ensure medications are utilized properly and as prescribed and that no illegal substances are present.
 - I realize that it is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by Dynamic Health Associates, P.A.
 - I will not use any illegal substances (cocaine, heroin, marijuana, crystal meth., ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of care at Dynamic Health Associates, P.A. effective immediately.
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- I will not alter my medication in any way (for example crushing or chewing tablets) or use any other auto-delivery (for example injection or insufflations) other than as prescribed by Dynamic Health Associates, P.A..
 - I understand that changing date, quantity or strength of medications or altering a prescription in any way, shape or form is against the law. Forging prescriptions or the provider’s signature is against the law. We will fully cooperate with law enforcement agencies locally as well as the Drug Enforcement Agency (DEA) regarding any infractions involving prescription medications. Violation of the law will be reported to the patient’s pharmacy, local authorities and the DEA.
 - I will discontinue all previously used pain medications, unless told to continue them by my physician at the Dynamic Health Associates,

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P.A.. You the patient also agree to inform other treating physicians that you are under controlled substance agreement at Dynamic Health Associates, P.A. I agree to address any concerns or issues regarding my treatment with my physician or authorized associate.

- If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I agree to gradually taper my medications as prescribed by the physician.
- I will not hold any member of Dynamic Health Associates, P.A. liable for problems caused by discontinuation of controlled substances, provided that I receive 15 days notice of termination.
- I agree to medication counts as needed, within a 24-hour notice.
- I recognize that my chronic pain represents a complex problem that may benefit from behavioral medicine strategies and psychotherapy. I also recognize my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of my treatment plan as directed by my physician in order to secure increased function and improvement in learning how to cope with my condition.
- I am permitting the right of disclosure to law enforcement in the event of violation or breach of this agreement.
- I agree to obtain my prescriptions from one pharmacy. The pharmacy I have selected is:

Name: _____

Location: _____ Phone: _____

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I, the patient, or the legal guardian/parent of the patient, acknowledge that a paper copy of the document was offered to me today.
I have elected to:

- 1) Take a printed copy of this document with me today
- 2) I refuse the printed document at this time.
I will access, read, download, or print this document from the web site of this practice

I understand that any violation of the policies contained herein may result in my permanent and irreversible discharge from the Dynamic Health Associates, P.A.

These protocols are per recommendations of the DEA. Please sign below:

I, _____, understand, accept and agree to the protocol and all the items listed above. I understand that failure to comply will lead to immediate termination of all prescription medications.

Print Name: _____ **Sign:** _____
This Consent was signed by the above

Relationship to patient: _____ **Date:** _____

Signature of Witness: _____