Dr Michelle Liske

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PHYSICAN PATIENT CONTRACT FOR CONTROLLED SUBSTANCE USE

I, ________________________________ agree to the following conditions:

1. I understand that I have a chronic pain problem that requires (Currently) the prescription of controlled substances to increase my function and I will not abuse these medications. The risk, side effects, and benefits of the medication have been discussed with me in detail
2. I will obtain prescriptions for controlled substances only from Dr Liske. **I will Not obtain controlled prescriptions from any other doctor, emergency rooms, urgent care clinics, etc.**
3. I will have prescriptions filled at only one pharmacy and will notify Dr Liske of the name of the pharmacy.
4. I will take the medication only as prescribed and will promptly notify Dr Liske if I do not.
5. I will meet regularly with Dr Liske to asses my progress. I understand that I will not have refills on the controlled substance unless I make it to these appointments.
6. If I am unable to make my appointment, then I will call and notify the clinic promptly. Otherwise, this will be considered a No show appointment. More that three No show appointments over a six month period will be considered as breach of contract.
7. **Lost, Misplaced, or stolen medications will Not be replaced. Refills will not be given early for any reason. Refills are only to be requested during normal business hours.**
8. As a new patient I will not be able to get refills on controlled substances until my medical records are received from my previous physician.
9. If despite medication treatment my pain condition does not improve, I agree to be referred to a pain management program.
10. Dr Liske will run a report with the department of justice regularly to ensure compliance to this contact.

If I deviate the above guidelines, I understand that I will be promptly tapered off medication.

Signature of patient:______________________ *Date:*__________________