CLEVELAND MEDICAL ASSOCIATES , PLLC

1060 William Way, NW
Cleveland, TN 37312
(423)478 -1050
(888)853 -7312

Kamran Farrukh, MD
Azhar Sheikh, MD
Nicole Bernatowicz,DO
Kent Chastian, MD
Daniel Vance, MD

PATIENT CONSENT TO RECEIVE A CONTROLLED SUBSTANCE

PATIENT NAME: _____

This agreement will be the basis for receiving prescription(s) for any controlled substance. Failure on your part to strictly abide by the following requirements may result in the loss of privilege of being given a prescription for any controlled substance. It is the goal of the practice to reduce or eliminate the cause of your pain. Pain comes from several sources: structural problems in the spine, spasm, nerve inflammation, and/ or joint inflammation. More than one type of treatment and more than one type of medication is required to treat each of these sources.

You must read each of the following items carefully, then your signature will be required to show that you have read and understand each provision. If you have any questions, ask for an explanation before signing.

- The decisions made by the provider will not be influenced by any type or amount of medication that you may have taken in the past.
- I will take medications at the dose and frequency prescribed.
- I will not increase or change how I take my medications without the approval of this health care provider.
- I will arrange for refills for these medications only at _____ pharmacy, phone number _____, with full consent for my provider and pharmacy to exchange information in writing or verbally.
- I will bring the prescription bottles of the medication I receive from this office to every appointment for the remaining pills to be subject to count.
- I will not request any pain medications or controlled substances from other providers, and I will inform this provider of all the medications I am taking.
- I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide the same to the emergency department providers.
- I will protect my prescriptions and medications. I understand that if lost, stolen or misplaced my prescriptions will not be replaced.
- Patient will be required to comply to Urine Drug Screen (at the providers discretion) and follow up appointment requirements set by their provider.
- I understand that if I am a woman of childbearing age and receiving a controlled substance, I should use an effective form of birth control and will inform my prescribing physician if I decide to try to become or do become pregnant.
- I understand that my provider may choose to terminate our relationship, discontinue prescribing controlled substances to me and/or refer me to pain management in the event of an abnormal drug screen.

Patient Signature: _____ Date: _____

CLEVELAND MEDICAL ASSOCIATES , PLLC

1060 William Way, NW
Cleveland, TN 37312
(423)478 -1050
(888)853 -7312

Kamran Farrukh, MD
Azhar Sheikh, MD
Nicole Bernatowicz,DO
Kent Chastian, MD
Daniel Vance, MD

PATIENT CONSENT TO RECEIVE A CONTROLLED SUBSTANCE

Patient Consent for Drug Testing

Cleveland Medical Associates is not a pain management facility and does not routinely prescribe pain medications and controlled substances. However, in some cases, individuals require these medications to be prescribed as part of their medical care.

The following policies exist regarding pain medications and controlled substances:

- Providers are REQUIRED by state law to check a database to verify additional scripts are not being obtained by other providers. If there are additional scripts being obtained by other providers when databases are checked, this office will not be able to write additional scripts for those medications
- Patients are REQUIRED by state law to update and/or notify providers immediately any changes in any medications.
- Periodic drug screening may be obtained by the providers of Cleveland Medical Associates and sent to the laboratory for testing during the course of treatment. Drug testing frequency is at the discretion of the provider.
- No prescriptions will be written early or rewritten due to prescriptions being lost or stolen.

Failure to comply with these policies will result in the cessation of these prescriptions by the providers at Cleveland Medical Associates.

By signing this paper, you are consenting to drug testing when your provider deems necessary. If you have any questions about the policies listed above, please ask before signing.

Failure to sign this agreement, if required, will result in no pain medications and/or controlled substances prescriptions written or filled at Cleveland Medical Associates.

Cleveland Medical Associates will, however, continue to prescribe any other medications needed for your medical care.

Name: (Print) _____DOB: _____

Signature: _____Date: _____

Witness: _____Date: _____

A copy of this document is available upon request.