PediatriCare Associates
Pediatric and Adolescent Medicine

Controlled Substance Prescription Agreement

Patient's Name: _____ DOB:_____

This is a contract because you or your child has been prescribed a controlled substance.
To meet strict state and federal guidelines and for our medical licenses, we are obliged to have agreements with our patients that are prescribed controlled substances.

Please read the agreement below carefully to ensure that you understand what you are agreeing to before signing this contract:

I, _____, agree to the following expectations:
Parent's Full Name (patient if 18 or over)

1. Appointments: Follow ups are done on an average of every 3 months, but may be more or less depending on every patient's needs. I agree to keep all scheduled appointments with my physician and other consulting physicians. Medication refills are contingent on keeping appointments. If I cannot keep an appointment for any reason, I must notify the office. I understand that repeatedly missing appointments will result in my medication being stopped.

2. Prescription Refills: I understand my prescription will not be refilled early or outside of regular office hours. I will give the office a notice of 3-4 business days for refill requests.

3. Continuity of care: I will try to follow up with the same physician for my prescription refills.

4. Lost or Stolen Medications: I am responsible for properly taking and safeguarding my medication. I understand that lost, stolen or damaged medications will not be replaced.

5. Illegal Behavior: I will not share, sell, trade, or otherwise permit others to have my medications. I understand that it is a felony. I am aware that committing a crime related to controlled substances is not protected by the "doctor – patient privilege". If the responsible legal authorities have questions concerning my treatment, ALL CONFIDENTIALITY IS WAIVED and these authorities may be given full access to Pediatricare Associates records of controlled substance administration.

_____
Printed Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Signature of Physician Date

PediatriCare Associates
20-20 Fair Lawn Avenue
Fair Lawn, NJ 07410
Phone: (201) 791-4545
Fax: (201) 791-3765

PediatriCare Associates
400 North Franklin Turnpike
Mahwah, NJ 07430
Phone: (201) 529-4545
Fax: (201) 529-1596

PediatriCare Associates
901 Route 23 South
Pompton Plains, NJ 07444
Phone: (973) 831-4545
Fax: (973) 831-1527

PediatriCare Associates
1225 McBride Ave
Woodland Park, NJ 07424
Phone: (973)-256-4545
Fax: (973)-826-8600

PediatriCare Associates
90 Prospect Avenue
Hackensack, NJ 07601
Phone: (201)-342-4001
Fax: (201)-342-9569