

Sleep Innovations  
2882 AAA Court  
Bettendorf, IA 52722

## Medication Management Agreement

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- 1. PURPOSE:** The purpose of the Medication Management Agreement is to prevent misunderstandings about certain controlled medications you will be taking, or may take in the future. This is to help both you and your provider to comply with the law regarding controlled medications. I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship that my provider undertakes to treat me based on this Agreement. This office protocol is designed to demonstrate a well supervised prescription program of controlled substance within our practice. This protocol does not have a patient preference for drug testing but is more on a random basis. The intent of random drug testing is to document supervised utilization of controlled substances and the effectiveness in patients we treat. These recommendations relate to physician liability insurance and the PMP (Prescription Monitoring Program) on continuation of controlled substances and prescription patterns for all providers.
- 2. VIOLATION:** I understand that if I break the Agreement, my provider will stop prescribing these medications, and may terminate my care with Sleep Innovations. In this case, my provider may choose to taper me off my medications or discontinue medications as deemed appropriate. This choice will be made by my provider.
- 3. COMMUNICATION:** I will communicate fully with my provider about how the medication is affecting my health/well-being (including but not limited to side effects, symptoms).
- 4. ILLEGAL DRUGS PROHIBITED:** I will not use illegal drugs, including but not limited to heroin and cocaine, while being prescribed controlled substances by Sleep Innovations. The practice of Sleep Innovations is based in Iowa but consults on patients in Illinois where marijuana is currently legal; please have a conversation with your provider as needed about marijuana use. Our office will **NOT** prescribe marijuana for any reason.
- 5. DRUG DIVERSION PROHIBITED:** I will not share, sell or trade my medications to anyone. Altering a prescription in any manner, selling medications or misrepresenting myself to a

pharmacy is a felony and will be reported to the police. I will only take medication that has been prescribed for me and not use other people's medication.

6. **PROTECTING MEDICATIONS:** I will safeguard my medications from loss or theft. If your medication is lost or stolen, our office will request a copy of the police report to be placed on file. To reduce instances of medication loss/theft, carry only the amount of medication needed while away from home. Lost or stolen medications will be addressed on a case-by-case basis as to if they will be replaced.
7. **REFILLS:** I agree that requests for renewals of my prescription for controlled medications will be made at the time of my office visit or during regular business hours for my provider. No renewals will be available under any circumstances during the evening or weekends.

**\*\*\*Patient must give at least 72 hours for refills to be addressed\*\*\***

Refills will be addressed in as timely manner as possible. I acknowledge that the office is not responsible to expedite refills in the case of my misunderstandings of the prescriptions (including but not limited to forgetting refill is/was due, taking prescription incorrectly)

8. **PRESCRIPTION MONITORING PROGRAM:** I am aware that my provider may review my controlled substance prescription records in the Iowa Prescription Monitoring Program operated by the Illinois Department of Human Services at any time during the course of my treatment to determine whether I have obtained prescriptions from other providers.
9. **DRUG TESTING:** I agree to submit to a blood or urine test, at my cost after insurance covers their portion, if requested by any provider in this practice to determine my compliance with my medication program. Refusal to submit to this test may result in the immediate termination of my care by the provider. If I am unable to give a specimen, it is considered a failed test.
10. **MISUSE OF MEDICATIONS:** I agree that I will use my controlled medications at a rate no greater than the prescribed dosing, and that use of my medication at a greater dose will result in my being without medications for a period of time. Continued misuse of controlled medications will result in termination of my care from this provider and/or this practice.
11. **UNDERSTANDING THIS AGREEMENT:** I agree that I understand all terms of this Agreement. Any questions or concerns of mine have been adequately answered. Copy of this signed Agreement will be placed in my medical record.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PROVIDER SIGNATURE:** \_\_\_\_\_