**MEDICATION MANAGEMENT CONTRACT**

**Steven A. Segal, M.D.**

1810 Broad Ripple Ave. Indianapolis, IN, 46220

This contract between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient) and Dr. Steven A. Segal (doctor) is for the purpose of establishing agreement between patient and doctor on clear understanding of conditions for the prescription, safe and proper use of DEA controlled medications prescribed by the doctors.

Doctors and patient agree that this contract is essential to the doctor’s ability to treat the patient’s illness effectively and the failure of patient to abide by the terms of this contract may result in withdrawal of all prescribed medications and the termination of doctor/patient relationship.

The patient agrees to and accepts the following conditions:

I declare that at this time I am not receiving prescriptions for any DEA controlled medications from any other health care providers. Dr. Segal is to be the only prescriber of this medication. I will not attempt to get DEA controlled medications from any other health care provider without informing them that I am getting such medications from Dr. Segal. If another health care provider is willing to prescribe such medication, Dr. Segal will have to approve of such arrangement to make sure there is no duplication.

I understand that the goal of these medications is a reduction in my symptoms, improvement in my ability to function and improvement in quality of life. If symptoms are controlled only with loss of function or there is any question regarding my performing any activity safely, I agree that I will not perform such activity; including driving a more vehicle until my ability to perform has been evaluated and I have not used the medication for at least three days.

I agree that I shall not adjust the dose of medications without permission from the doctor and I shall take medications only as prescribed. Any change in dose without doctor’s permission will result in termination of prescription.

I will not share, sell or trade any DEA controlled medication.

I agree that I shall be responsible for safeguarding my medications from loss or theft. If medication is lost or stolen, this will be reported to the doctor as well as to the local authorities, including the police and the Federal drug Enforcement Administration. A police report will be required before any prescription will be replaced.

I understand that refills of such medications will be made only during office hours and not over the phone or as an emergency at nights or weekends. All prescription renewals will be in person. Prescriptions will be written on an exact time basis only. Doctors will decide how often patients’ needs to come in for renewal of prescriptions.

I agree to use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pharmacy, located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for all my DEA controlled medications. If I change pharmacy, for any reason, I agree to notify doctors and advise my new pharmacy of my previous pharmacy and telephone number.

I agree to waive my applicable privilege or right of privacy or confidentiality with respect to the prescribing of my controlled medications. I authorize the doctor and pharmacy to cooperate fully with any city, state of federal law-enforcement agency in investigating any possible misuse, sale or other diversion of my DEA controlled medications. I authorize the doctors to provide a copy of this contract to my pharmacy and any other physicians known to have prescribed controlled medications for me.

I agree to submit to any urine, blood or other tests requested by the doctors to determine my compliance with the regimen of medications.

I understand that the medication regimen will be continued for a period of four months, and may be renewed after review. But if there is no evidence that I am improving or making any progress in improving function or quality of life, these medications may be tapered or stopped, further tests may be ordered, or my care may be referred to an appropriate specialist.

I have read this contract and the doctor or their staff has explained it to me. I fully understand the consequences of violating this contract.

I acknowledge receipt of a copy of this contract.

Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_