



mosaic health

Better happens together.

Patient Account # _____

Patient Controlled Substance Rules and Acknowledgement

Mosaic Healthcare providers are committed to doing all they can to treat patient's chronic pain condition or behavioral health condition. In some cases, the prescribing of controlled substances will be utilized to manage patient's chronic pain or to treat behavioral health conditions. Controlled substances are strictly regulated by local, state and federal agencies and this document is used to establish rules to protect both the Mosaic Health patient and the Mosaic Health healthcare provider who is the prescriber of the controlled substances.

As a Mosaic Health patient, I _____ (print name), with a date of birth of _____ acknowledge the following rules in order to have a controlled substance prescribed for me by a Mosaic healthcare provider:

1. **I acknowledge** that all controlled substances will be prescribed by my Mosaic healthcare provider. I further understand that during his/her absence, a designated Mosaic Health covering provider may be authorized to prescribe unless specific authorization is obtained for an exception.
2. **I acknowledge** that I will not seek prescriptions for controlled substances from any other healthcare provider, including dentists, while receiving controlled substances from Mosaic Health.
3. **I acknowledge** that it is unlawful to be prescribed the same controlled substance by more than one healthcare provider at the same time and if that should occur I will notify my Mosaic healthcare provider immediately.
4. **I acknowledge** that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a healthcare provider, or his/her staff, or knowingly withholding facts from a healthcare provider or his/her staff (including failure to inform the healthcare provider or his/her staff of all controlled substances that I have been prescribed).
5. **I acknowledge** that I must inform the healthcare provider about all drugs that I am taking, have purchased, or have obtained. This includes over-the-counter medications as failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.
6. **I acknowledge** that I must obtain all prescribed controlled substances at the same pharmacy and have given this information to the Mosaic healthcare provider or Mosaic Health staff member. I further acknowledge that if I need to change pharmacies or provide an alternative pharmacy, I must inform the Mosaic Health provider immediately.
7. **I acknowledge** that I will not share, sell, or otherwise allow others, including my spouse or family members, to have access to any controlled substances that have been prescribed for me.
8. **I acknowledge** that I will cooperate with requested and unannounced urine or serum toxicology specimens (drug tests) within one business day.
9. **I acknowledge** that I may be discharged from the Mosaic Health practice(s) if an

- unauthorized substance is present in my urine or serum toxicology screens (drug tests) or if the controlled prescribed medication is not present in urine/serum toxicology screen.
10. **I acknowledge** that I will not consume alcohol in conjunction with controlled substances.
 11. **I acknowledge** that I will not use, purchase, or otherwise obtain any other legal drugs, except as specifically authorized by an Mosaic healthcare provider. **I acknowledge** that I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc.
 12. **I acknowledge** that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges, injury or death.
 13. **I acknowledge** that written prescriptions for controlled substances may not be replaced if they are lost, stolen, get wet, are destroyed, or otherwise misplaced unless explicit written proof is provided with direct evidence from legal authorities.
 14. **I acknowledge** that early refills will not be authorized.
 15. **I acknowledge** that renewals are based upon keeping my scheduled appointments with my Mosaic healthcare provider or a healthcare provider I have been referred for specialty care.
 16. **I acknowledge** that I must not phone for prescriptions after hours or on weekends through the answering service as they will not be filled.
 17. **I acknowledge** that if I am arrested or incarcerated related to legal or illegal drugs (including alcohol), neither refills or renewals on controlled substances will be given.

As a Mosaic Health patient, **I acknowledge** that the failure to adhere to these rules will result in the termination of my controlled substances being prescribed and possible discharge from all Mosaic Health practices. **I further acknowledge** that law enforcement officials will be contacted due to my failure to comply with local, state or federal laws.

I finally acknowledge through my signature below that I am not under the influence of alcohol or drugs and that I have full right and power to sign and be bound by these rules, and that I have read them, understand them, accept them and have been given a copy of them.

Signature of Patient

DATE

**Signature of Parent or Legal Guardian
(If patient is unable to sign or is a minor)**

Relationship to Patient

Mosaic Health Staff Witness Signature

DATE