Seaver, Pittman, and Cagle D.D.S.

Prescription Medication & Controlled Substance Policy

The office of Drs. Seaver and Pittman has developed this mutual agreement to pertain to the treatment of my medical conditions. I understand that the goal of treatment is to improve my functional ability, and in doing so, that sometimes requires narcotics and/or sedatives. These medications sometimes lead to abuse and dependency, though if used correctly, can be very effective. By **initialing** (no check marks) and **signing** this document in the appropriate areas below, I understand my responsibility and agree to uphold this agreement.

___ I agree to obtain my prescriptions related to my medical/dental conditions only from this office. I understand that if another physician gives me a prescription for the same medication prescribed by this office, that I will notify that physician, as well as our office.

___ I will not ask for my medications to be dispensed or refilled early and I will allow 72 hours for these medications to be refilled if necessary. **Request for refills are to be made during business hours only!!! No emergency phone calls for refills or changes in medications will be taken by our answering service!!! I understand and will only make my request during business hours and will only use one pharmacy for my prescriptions!**

___ I will not share or trade prescriptions with anyone.

___ I will bring unused medication into our office for disposal in the event that a different strength of drug or alternate drug needs to be prescribed. No additional prescriptions will be given with unused medications not returned.

___I am responsible for all medications. If they become lost, stolen, misplaced or if they disappear for any reason, I will not ask for refills early or new prescriptions to replace them.

___ I understand that my doctors will cooperate with any and all authorities, as these medications are monitored by governmental agencies.

___I understand that while taking narcotics and/or sedatives that my ability to drive, operate machinery or make important decisions will be altered and I release my physician/ dentist of any liabilities stemming from my impairment. I will follow my doctors' instructions on how to use my medications and will adhere to their instructions.

___I understand that governmental agencies notify my doctor/dentist of over usage or potential for abuse and if notified of unusual prescription history, my physician/dentist will consult with each other prior to any further prescriptions being written. My doctors/dentist has the right to refuse certain medications if abuse potential is at risk or suspected.

___ I understand any altering of original prescriptions will result in immediate dismissal from our practice and notification of authorities. I also understand that failure to keep appointments, except in cases of emergency, may also result in dismissal.

Please make sure to initial each line.

_____ _____

Patient or Guardian **Date**

_____ _____

Witness Date