Bluewater Medicine
Kenneth W. Ponder, M.D., P.A.

MEDICATION MANAGEMENT **AGREEMENT**

This Agreement between _____,Date of Birth:_____ ("Patient") and Kenneth W. Ponder, M.D., P.A. ("Provider") is for the purpose of establishing agreement between Provider and Patient on clear conditions for the prescription and use of Drug Enforcement Agency (DEA) controlled medications prescribed by the Provider for the Patient. Provider and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. The Patient agrees to and accepts the following conditions for the management of controlled medication prescribed or provided by the Provider for the Patient:

I understand that improvement in my quality of life are the goals of this program. I realize that all of the medications have potential side effects, and some have the risk of addiction. I will have the recommended laboratory studies required to keep the regimen as safe as possible.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

I will see the provider face to face in the office, every 3 months for refills, as **required** by Florida Law HB 7095, 2011.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell, or trade my medication for money, goods or services.

I will not attempt to get controlled medication from any other health care provider without telling them that I am taking controlled medication prescribed by the Provider. I understand it is against the law to do so. If my primary care physician is willing to prescribe my medications, the Provider will have to approve the arrangements to make sure there is no duplication. **I will discontinue all previously used controlled medications, unless told to continue them.**

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

I agree to use _____ Pharmacy, located at _____, telephone number _____, for all my controlled medication. If I change pharmacy for any reason, I agree to notify the Provider at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy's address and telephone number.

I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my controlled medication and I authorize the Provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medication. I authorize the Provider to provide a copy of this Agreement to my pharmacy.

I agree that I will submit to a blood or urine test if requested by my Provider to determine my compliance with this agreement and my regimen of controlled medication. Periodic inquiries by the Provider into the State controlled medication prescribing database may be performed.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time, **and could possibly cause my death.**

I understand that this medication regimen will be reviewed periodically. If there no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regimen will be tapered and/or discontinued.

Provider and Patient agree that this Agreement is essential to the Provider's ability to treat the Patient's condition effectively and provide medical services. Failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Provider and the termination of the Provider/Patient relationship.

This agreement is entered into on this _____ day of _____, 20_____.

Patient Signature **X** Provider Witness