NEON CONTROLLED SUBSTANCE AGREEMENT

I, _____, understand that in order to receive Controlled or Ohio-monitored medication prescriptions from NEON medical providers, I agree to and will comply with the following:

A. MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT: Behavioral health assessment and/or continuing psychological therapy may be required. If I am currently involved in behavioral health therapy, or if I enter such therapy, I will authorize my behavioral health provider to exchange unrestricted information regarding my condition and treatment with the undersigned medical provider. Pain management consultation and/or continuing pain specialist therapy may be required. If I am currently involved in pain management care, or if I enter such therapy, I will authorize my pain consultant or specialist to exchange unrestricted information regarding my condition and treatment with NEON medical providers.

B. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with my regular NEON medical provider before making any change in either the dose or frequency of my medications. There will be no early refills of Controlled or Ohio-monitored medications. These medications must all be obtained from the same pharmacy each time (any exception must be approved by a NEON medical provider).

C. DRUG SEEKING: I will neither seek nor fill prescriptions for any Controlled or Ohio-monitored medication from any other health care provider unless approved by a NEON medical provider.

D. DRUG SCREENING: I will participate in drug screening as a part of my treatment plan if so desired by a NEON medical provider. Drug screening may include urinalysis, blood testing or pill counts. Refusal to submit to screening at any time may result in the discontinuation of Controlled or Ohio-monitored prescriptions by NEON medical providers.

E. ILLEGAL & NON-PRESCRIBED DRUG USE: I understand that the use any Controlled or Ohio-monitored medication not prescribed by NEON medical providers may result in termination of these prescriptions. I authorize NEON to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of Controlled or Ohio-monitored medicines and that until such investigations are resolved, I will not receive any Controlled or Ohio-monitored prescriptions from NEON medical providers. I also understand that if I present to any NEON health center for any reason and appear to be intoxicated I will no longer be prescribed Controlled or Ohio-monitored prescriptions by any NEON medical provider.

F. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by NEON medical providers and understand that lost or damaged medications will not be replaced.

G. PRESCRIPTIONS WHILE TRAVELING: If I plan to be out of state longer than 30 days, I will need to arrange for health care at my travel destinations and should not expect from NEON medical providers a prescription quantity any greater than what is needed for one month of therapy.

I. SURVEILLANCE: I understand that NEON medical providers are required to check the Ohio Automated Rx Reporting System website (www.ohiopmp.gov) for any abnormal pharmacy dispensing activity related to me. I will no longer be eligible for Controlled or Ohio-monitored prescriptions if abnormal activity is reported at this website and such activity violates this Agreement.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION BY THE NEON MEDICAL PROVIDER NOTED BELOW.

_____

NEON Medical Provider: Printed Name

_____

Patient: Signature & Date