Kimberly N. Works, MD, FAAP
Pediatric Works, LLC
6065 Lake Forrest Dr., Ste 250
Atlanta, GA. 30328

Controlled Substance Addendum

Today's Date:
Name of Person Completing this form:
Patient Name:
Patient Date of Birth:

Controlled Substance Agreement contract between patient and/or guardian with Pediatric Works, LLC and Dr. Kimberly N. Works. Parent/guardian should sign this form if patient < 18 years and by signing they commit to ensure the patient is in compliance with the terms of the contract. If patient is > 18 years old, they will sign the form.

Patient and Parent Responsibility

1. I agree to take any Controlled Substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my Control Substances Physician . *

2. I agree to only take Controlled Substances prescribed by Kimberly N. Works, MD, FAAP, Pediatric Works, LLC *

3. I agree to safekeeping my Controlled Substance prescriptions and medications. I understand that lost, misplaced, or stolen prescriptions or medications will not be replaced. *

4. I will bring in all Controlled Substance medications in their original pill container for random counts within 24 hours of when requested. *

5. I will NOT combine any narcotic medication with consumption of alcohol. Any Urine Drug Screen (UDS) that is positive for both Controlled Substances and alcohol will be considered violation of this contract. *

6. I will NOT combine any controlled substance with illegal/street/recreational drugs. Any UDS that is positive for both prescribed Controlled Substances and illicit substances will be considered a violation of this contract. *

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7. I will be responsible for making and keeping appointments for Controlled Substance refills at least every 3 months unless otherwise discussed with Dr. Works. I understand that NO refill will be written outside of my appointment and I will NOT contact the office for refills of these medications. *

8. I will be responsible for having a working phone number which the office will use to contact about random UDS and pill counts. I understand that once notified by the office, either direct or by voicemail, I will have 24 hours to report, or inability to do so will result in a violation of t contract. *

9. I understand that not all insurances cover the cost of Drug Screening and that I may be responsible for part or the entire bill. *

10. I understand that I will not receive any Controlled Substances until my Physician has been ab to review my medical records. If I am a new patient, I understand that it is my responsibility to ensure my medical records have been obtained from my previous provider. *

11. I will not sell, share, or give away any Controlled Substance prescribed to me by my Physician with any other person. *

12. I will not lie or tell misleading information to Dr. Works or any of the Pediatric Works staff. *

13. I will not make threatening remarks in an attempt to get Controlled Substances from Pediatric Works staff or Dr. Works. *

14. I agree to have both Teacher and Parent Vanderbilt Forms completed prior to new prescriptions or whenever asked to do so.*

Physician Responsibility

By initialing each section the Patient/Guardian agree they understand the Physician's responsibility when prescribing a controlled substance for the Patient.

14. Physician will Provide the best evidence-based care for Patient based on the type of pain or medical condition they have. *

15. Physician will help set functional and pain control goals with me/patient when indicated.*

16. Physician will obtain a random drug screen at least once a year (may be from blood, urine, saliva based on physician discretion) *

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17. Physician will only refill-controlled substances on a monthly basis or at your designated medication refill appointment *

18. Physician will obtain before every appointment a report from Georgia Prescription Monitoring Program, which shows all controlled substances Patient has been prescribed including: a. Who wrote the script b. Which pharmacy filled the script c. What medication, d and quantity were filled. *

19. Physician will assess the risk/benefit/safety of Patient's medications including: a. Side effect Functional abilities c. Pain control *

Consequences of NOT adhering to any part of this contract

20. Prescribe any controlled substance for Patient. It will be at physician discretion to decide if a taper of medication will be given. *

21. May stop providing medical care for Patient. *

22. May refer Parent or Patient for drug abuse treatment *

Consequence for NOT signing this contract

We will not prescribe controlled substances for you.

By clicking this Checkbox, you agree to the terms of this controlled substance agreement (Clicking this box functions as a signature.) []

Name of Patient (if > 18 years) or Parent/Guardian (if Patient < 18 years):
Date:

Kimberly N. Works, MD, FAAP:
Date: