Primary Pharmacy Name and Address: _____

I will supply proper identification for my prescription upon receiving it. If my provider and I agree on an alternative person to pick up my prescription, that person must be 18 years or older and they will need to provide proof of identification upon pick-up. This person must be a designated individual and I may be asked to sign a Patient Authorized Liaison Form (PALS) form. The provider may at any time refuse to allow an alternative person to pick up the prescription even if designated.

A urine screen for the prescribed medicine and other prescriptions and illicit drugs can be requested at the time I arrive to pick up my prescription or I may be asked during any visit to provide one. **I will be financially responsible for any portion of this test that my insurance does not cover.**

I am responsible for my medications and written prescriptions. I will not share, sell or trade medications. Lost, misplaced, stolen or accidentally destroyed prescriptions (i.e. printed paper prescriptions) or actual medications **will not be replaced, even if a police report is provided**.

I will safely store medications. Controlled substances should be stored in a safe and secure place, such as a locked cabinet or safe. **I will not destroy or dispose of medications without specific instructions from my provider**. My provider may instruct me to bring in medications for disposal or use another appropriate method of disposal: medications may be returned to a take-back location or mixed with a small amount of water and an undesirable waste substance such as used coffee grounds or cat litter. For additional information and resources on safely disposing of medications, go to the website: www.nh.gov/medsafety.

I agree to bring in all of my pill bottles and remaining pills if requested by my provider. I may be asked to come into the office the same day as the notification. I will follow this request to the best of my ability. Failure to comply with this request is considered a violation of this agreement.

I understand that a copy of this agreement may be provided to the ER, pharmacy or other providers involved with my care.

SHOULD I CHOOSE TO USE THIS MEDICATION IN ANY WAY OTHER THAN THAT PRESCRIBED, I AGREE THAT MY PROVIDER WILL NOT BE RESPONSIBLE FOR ANY DAMAGE TO MY HEALTH, OTHER PERSONS, OR PROPERTY.

I UNDERSTAND THAT ANY VIOLATION OF THIS AGREEMENT MAY RESULT IN THE IMMEDIATE TERMINATION OF MEDICATIONS PRESCRIPTIONS, AND POSSIBLY TERMINATION OF ALL SERVICES FROM MY CONTROLLED SUBSTANCE PROVIDER. IF THE VIOLATION INVOLVES SUSPECTED ILLEGAL ACTIVITY, I UNDERSTAND THAT THE INCIDENT MAY ALSO BE REPORTED TO OTHER HEALTHCARE PROVIDERS, PHARMACIES, AND OTHER LEGAL AUTHORITIES, AS REQUIRED BY LAW.

Informed consent: This document has been reviewed with me and my questions have been answered. My signature below verifies I understand the information.

_____ Date:

Patient Signature