Bion Healthcare

Opioid Management Program

Controlled Substance Treatment Agreement

This agreement outlines the policies and expectations of Bion Healthcare for prescribing **controlled substances**, including opioid medications. These guidelines are in place to ensure **safe, responsible, and effective treatment** for patients who require these medications for ongoing care.

Please **initial each section** to confirm that you have read, understood, and agree to the terms below.

_____ 1. I agree to take my medication only as prescribed.
I will not increase the dose or change how I take the medication without clear approval from my provider.

_____ 2. I have received a copy of the Bion Healthcare Opioid Management Plan
I agree to follow this plan, including guidance on using controlled substances from other sources such as dentists or emergency rooms.

Controlled substances include but are not limited to:

- Opioid pain relievers
- Anti-anxiety medications (e.g., Xanax, Klonopin, Valium)
- Stimulants (e.g., ADHD medications, appetite suppressants)

_____ 3. I will not take, borrow, or try medications from any other person.

_____ 4. I will not use leftover or expired medication, even if it was previously prescribed to me.

_____ 5. I will not sell, share, or trade my medication with anyone—including friends, family, or my spouse.

_____ **6. I will not take more medication than prescribed without approval.**
Example: If my prescription is for 3 pills per day, I cannot increase this dose on my own.

_____ **7. I will avoid foods with poppy seeds or similar ingredients,**
as they may interfere with drug testing. This includes poppy seed muffins, bagels, dressings, or "everything" bagels with black seeds.

_____ **8. I understand that my medications have street value and must be kept safe.**

- I am responsible for my prescriptions.
- Lost or stolen medications **will not** be replaced.

_____ **9. I agree to drug testing when requested.**
This may include urine, saliva, or blood screens—random or scheduled.
If I need to use the restroom before my appointment, I will ask staff if a sample is needed to avoid delays.

_____ **10. I agree to pill counts if requested.**
This may include in-person visits or virtual pill counts (sending a photo via text within 24 hours).

_____ **11. I understand that all prescription refills require an appointment with a provider.**
Appointments may be in-person or via telemedicine and is up to the provider's discretion.

_____ **12. I will keep my medication in its original labeled container.**
This is to prevent contamination or misuse.

_____ **13. I understand that my provider may reduce or stop opioid therapy if risks outweigh the benefits.**
This may include concerns about misuse, changes in health (e.g., lung or mental function), or suspected diversion.

Important Note:

These rules are **non-judgmental** and are designed to support your care and safety. If a rule is broken—intentionally or not—it may lead to the **discontinuation of controlled substances** from our office.

Acknowledgment

I have read and understood the policies above, have had the opportunity to ask questions, and agree to follow these guidelines as part of my treatment at Bion Healthcare.

Patient's Full Name: _____
Date of Birth: ____ / ____ / _____
Patient Signature: _____
Date: ____ / ____ / _____
