Charles A. Evans M.D., PhD, PA
203 Christie St.
Lufkin, Texas 75904
936-699-5433
FAX: 936-699-5465

Patient Controlled Substance & Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management, anxiety and/or sleep disorders. This will help you and your provider comply with the law regarding controlled pharmaceuticals.

I agree that refills of my prescriptions for any controlled substance medication (for pain, anxiety or sleep) will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.

I will inform my physician of any medications I am taking prescribed by any other physician.

I will bring all controlled medications to my office visits that are prescribed to me by another physician.

I will not use any controlled medications, including cocaine, etc.

I agree to use my medication prescribed by my physician.

I will not share, sell or trade my medications with anyone.

I agree to use _____ pharmacy, located at _____.

The pharmacy's phone number is _____.

I authorize the provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled substances. I understand if I break this agreement my provider will not provide any controlled medication prescriptions.

I agree to follow the guideline above. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me at my request.

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

Patient signature _____ Printed _____

Witnessed by _____ Printed _____