



Original Date: 11/01/06

Dates Revised: 070109

Kara Diersing Clapp, PhD, NP-c
Family Nurse Practitioner

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CLIENT AGREEMENT: CONTROLLED SUBSTANCE CLASS II-III

This agreement is strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):

M F DOB:

Social Security Number (last 4 digits only):

TERMS AND CONDITIONS OF THIS AGREEMENT:

1. I understand that initial treatment consultation will provide only 3 days of controlled substance before requiring a follow-up visit with Dr. Kara.
2. I understand that subsequent treatment consultation will provide only a 7-day supply of controlled substance before requiring a follow-up visit with Dr. Kara.
3. I understand that only a 31-day total supply of controlled substance may be provided by Dr. Kara as treatment of acute pain. Pain that remains unresolved after 31 days will require a referral to a pain specialist for further evaluation and treatment.
- 4. I agree to receive controlled substances from Dr. Kara only and will not seek additional controlled substances from other providers, clinics, hospitals, Emergency Room departments.**
5. I understand that Dr. Kara may elect to request a DOPL report from the state of Utah without my knowledge or consent to confirm that I have not violated the terms of this agreement.
6. I agree to maintain my follow-up appointments with Dr. Kara as scheduled. In the event I cancel an appointment, I will not expect Dr. Kara to renew my controlled substance prescriptions until she has completed a face to face assessment of my condition and response to treatment.
7. To facilitate provider communications with other treatment plan team members, **I agree to have my controlled substance prescriptions filled only by the following pharmacy:**

Pharmacy Name Address and Phone Number: _____

8. I agree to maintain current and correct contact information with Dr. Kara during the time I am receiving controlled substances from her.
9. I agree to maintain personal custody of and control over my controlled substances to prevent accidental loss or theft. I understand that I cannot ask Dr. Kara to replace them in the event of accidental loss or theft, regardless of the circumstances of the loss or theft.
10. I may be asked to have a sleep apnea study completed during the course of my treatment plan to rule out central apnea. Refusal to have a sleep study done will invalidate this agreement and end any controlled substance prescribing from Doctor Kara, P.C.
11. I understand that my privilege to receive controlled substances from Dr. Kara, as a part of my medical treatment plan, will remain intact as long as I maintain the conditions of this agreement. In the event that I do not follow the conditions of this agreement, Dr. Kara has the right to terminate her willingness to provide me with controlled substances as a part of my treatment plan. Violations of this agreement do not terminate my non-pharmaceutical portion of the treatment plan. I understand that Dr. Kara will use my contact information to provide me written notice within 3 business days of the termination of controlled substance portion of my treatment plan. It is my responsibility to notify Dr. Kara of any changes in my contact information.

12. **(Interim Chronic Pain Clients Only)** I am scheduled with _____ on _____
 I acknowledge that I may receive controlled substances from Dr. Kara only until the date of the appointment as listed above or until Dr. Kara has confirmed that the Pain Specialist is able to assume responsibility for the treatment plan established by the specialist. Appointment cancellations and reschedules initiated by me will void the contract I have with Dr. Kara. In the event of appointment reschedules initiated by the pain clinic, Dr. Kara will confirm the re-schedule request with the pain clinic in order to validly and potentially extend the length of this interim contract.

SIGNATURES:

Client Signature:

Date:

Provider Signature: Kara Diersing Clapp, PhD, NP-c

Date: