Patient Agreement Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of Controlled Substance medications like stimulants (Adderall, Ritalin, Concerta, Focalin etc.) and benzodiazepines (Xanax, Klonopin, Ativan, etc.) may cause addiction and is only one part of the treatment my psychiatric condition.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury. Certain combinations of medications and alcohol/street drugs can cause me to stop breathing and lead to injury or death.
2. I should not drive or operate machinery if feeling sedated.
3. I may get addicted to this medicine.
4. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
5. If I need to stop this medicine, I must do it slowly or I may get very sick. (High Doses of Benzodiazepines only)
6. It may be dangerous to mix this medication with some prescription medications- so I need to inform ALL my providers about ALL the medications I take.

I agree to the following:

I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else’s medicine. I will not increase my medicine until I speak with my prescriber. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed. If requested, I will bring the pill bottles with any remaining pills of this medicine to each clinic visit. I agree to give a blood or urine sample, if asked, to test for drug use.

**Refills**

Refills will be made only my provider’s office hours—Monday through Friday, 9:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-Thur) to ask for a refill of my medicine. No early refills may be made. If I no show or cancel an appointment, my provider will determine if it is appropriate and safe to refill my medication.

**Pharmacy**

I will only use one pharmacy to get my medicine. My prescriber may talk with the pharmacist about my medicines.

The name of my pharmacy is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescriptions from Other Doctors**

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must call the office to inform my prescriber of the medication, dosage and purpose of the medication.

**Privacy**

While I am taking this medicine, my prescriber may need to contact other prescribers to coordinate safe care. I agree to sign a release of information for other providers.

**Termination of Agreement**

If I break any of the rules, or if my prescriber decides that this medicine is hurting me more than helping me, or this medicine is no longer necessary this medicine may be stopped by my prescriber in a safe way. **If I do not return for a medication visit in the requested time period, I understand I may not be able to receive refills.** I have talked about this agreement with my prescriber and I understand the above rules.

Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_