IMPACT PSYCHIATRIC CARE, LLC

Patient Provider Controlled Substance Agreement

Patient Name _____ DOB _____

1. **We wish to have clear, shared goals for your treatment.**
   a. I am being treated with controlled medications for a diagnosis of _____.
   b. The goal of my treatment is to improve my functioning.
2. **We want you to be safe in taking these medications.**
   a. I should take controlled medications only as prescribed. I will not change the dose unless directed by my Provider.
   b. I will report side effects to my Provider for each controlled medication taken.
   c. I will not give or sell these medications to anyone.
   d. I agree to attend all required follow up visits as this allows monitoring of my medications.
   e. I will store these medications safely so that they cannot be stolen or taken by other people. I know that lost or stolen medications will not be replaced.
   f. If I have unused medications, I will dispose of them through drug drop off sites and through drug take back days.
   g. I will tell my Provider all other medications that I take and let her/him know right away if I have a prescription for a new medication.
   h. I will not use controlled medications which are not prescribed for me and I will not use illegal substances.
   i. I will use only one pharmacy for controlled medications. I will notify the Provider if that pharmacy changes.
   j. I agree that my Provider may share information about my use of controlled medications with my pharmacy, with emergency rooms and with other Providers involved in my care.
   k. I agree to keep my appointments and to notify my Provider and reschedule when I must miss one.
   l. I agree to notify my Provider if my health changes in an important way or if I become pregnant.
   m. I will sign releases so that my Provider can share information with all other Providers involved in my care.
   n. I will treat Providers, staff at the office or on the phone with respect at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.
3. **We must monitor these medicines carefully.**
   a. I will bring in pill bottles for each visit.
   b. I understand that if I lose my medications or they are stolen, my medications could be stopped.
   c. I know that my Provider and/or team member will regularly look at the Prescription Monitoring Program to review all my prescriptions for controlled substances.
4. **We want to manage these prescriptions in an orderly manner.**
   a. I understand prescriptions will be for 30 days at most and may not have refills.
   b. I understand that I may not request early refills or phone refills for any reason.
   c. I understand refills will only be provided at scheduled appointments.
   d. I understand that the pharmacy where the medication was sent at the time of the visit will not be changed after the visit. If I decide to use a different pharmacy the medication will not be transferred.
   e. I understand that I am responsible to provide the provider with the correct pharmacy at the time of the visit otherwise the pharmacy on file as the preferred pharmacy will be the default pharmacy.
   f. I understand that it is my responsibility to contact the pharmacy several days in advance of needing my prescription filled to ensure that the pharmacy has the stimulant medication in stock. Typically, it takes 1-3 business days for a pharmacy to order the medication if they do not have it in stock. Should I wait until they are out of medication, I may have to wait for the pharmacy to order the medication resulting in a lapse in medication for several days.
   g. I understand that if a partial fill of a stimulant medication is accepted this will void the remainder of the prescription and a new prescription will not be provided between visits. A partial fill should be refused and only picked up once the pharmacy has the medication available to fill the prescription in its entirety.
5. **In addition, Impact Psychiatric Care, LLC policy also requires that:**
   a. If a controlled medication is indicated for short term use, my medication will likely be tapered and stopped by my Provider.
   b. Failure to comply with the terms of the Patient/Provider Controlled Substance Agreement will be addressed with the patient and documented. Noncompliance of this Agreement may result in discontinuation of the controlled substance or the termination of the Patient/Provider relationship.

x _____

Signature: Provider **Date**

x _____

Signature: Patient or Legal Guardian **Date**

x _____

Patient/Legal Guardian Printed Name **Date**

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