IMPACT PSYCHIATRIC CARE, LLC

Patient Provider Controlled Substance Agreement

Patient Name _____DOB_____

1. **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 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.
   j. I agree to keep my appointments and to notify my Provider and reschedule when I must miss one.
   k. I agree to notify my Provider if my health changes in an important way or if I become pregnant.
   l. I will sign releases so that my Provider can share information with all other Providers involved in my care.
   m. 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 and I may be discharged from the practice.
2. **We must monitor these medicines carefully.**
   a. I will bring in pill bottles for each visit. When seen in person.
   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.
3. **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 I will be required to have an in-person appointment at the office once yearly while on a controlled substance and an in-person appointment when a controlled substance is started.
   e. I understand that if I fail to make the scheduled in-person appointment the controlled substance medication will be discontinued.
   f. 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.
   g. 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.
   h. 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 medication in stock. I understand that if the pharmacy does not have the medication in stock, I will have to wait until the pharmacy has it in or schedule an appointment to have it sent to another pharmacy.
   i. 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.
4. **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: Patient or Legal Guardian **Date**

x_____

Patient/Legal Guardian Printed Name **Date**

719.301.7731 | F 719.434.9730
www.impactpsychiatriccare.com | info@impactpsychiatricare.com