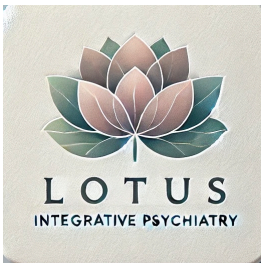


Controlled Substances Agreement

Patient Name_____

DOB_____

The use of _____for_____

may cause addiction and is only one part of the treatment for

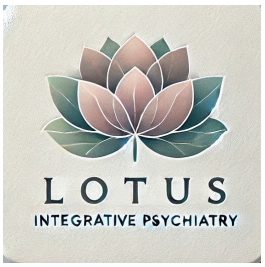
_____

I have been informed that:

- If I drink alcohol or use other drugs, I may not be able to think clearly, and I could become sleepy and risk personal injury or death.
- I may get addicted to this medicine.
- If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
- If I need to stop this medicine, I must do it slowly or I may get very sick, and in some cases risk death.

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 provider.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments
- I will bring the pill bottle(s) 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 during regular business hours. Please call at least 3 business days ahead to ask for a refill. I must keep track of my medications. No early refills will be made.

Prescriptions from other providers

If I see another doctor who gives me a controlled substance medicine, I must inform Lotus Integrative Psychiatry.

I have talked to my provider, and I understand these rules.

Patient signature _____ Date _____

Provider signature _____ Date _____