DR.B
PSYCHIATRY

Dr. B Psychiatry Consult, PC
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Board Certified Adult Psychiatrist

Controlled Substance Agreement Form

Patient:
DOB:
MRN:
Date of Service:

The purpose of this Controlled Substance Agreement ("Agreement") is to prevent misunderstandings about certain medicines you will be prescribed for your condition. This Agreement is for compliance purposes related to laws regarding controlled substances.

1. I understand that this Agreement is a component of the trust relationship between a prescriber and patient and that my prescriber will prescribe controlled substances to me based on my agreeing to abide by this Agreement.
2. I understand that if I break any of the terms of this Agreement, the prescriber/patient relationship could be terminated and I could be asked to move my care and find another prescriber outside of Dr. B Psychiatry Consult, PC. Alternatively, my prescriber and other prescribers at Dr. B Psychiatry Consult, PC may lower my current medication dose, change or stop prescribing a controlled substance, or make other referrals as needed, such as pain management, chemical dependence treatment, etc.
3. I will make and keep scheduled appointments with my specific prescriber on a regular basis. If I do not make and keep scheduled appointments, my prescriber may choose to not refill my medication.
4. I will avoid making appointments with an alternate prescriber on short notice. I understand, that if I do make such appointments, the alternate prescriber may choose to not refill my medication.
5. Each prescriber exercises discretion and independent medical decision making as to what is most appropriate for me, including whether a medication I was previously taking is to be continued.
6. I understand that if I transfer my care to a new provider, (s)he will perform an assessment and may elect to continue or modify my treatment plan based on the updated assessment.
7. I agree that refills of my prescriptions for controlled substances will be made only at the time of an office visit and during regular office hours. Office visits for controlled substances are not medical emergencies and my requests for last-minute appointment requests may not be able to be accommodated.
8. No requests for refills of my prescriptions for controlled substances will be approved during evenings or on weekends.
9. I will communicate fully with my prescriber about the character and intensity of my symptoms (for example pain, anxiety, and ADHD symptoms), the effect of the symptoms on my daily life, and the extent to which the prescribed medicine is relieving my symptoms.
10. I will not use any illegal controlled substances and will not use any prescription drugs that were prescribed to someone else.
11. I will not share, sell or trade my medication, and I understand that it is illegal to do so.
12. I understand it may be unsafe to be prescribed the same or similar controlled substances by more than one prescriber.

13. I will not obtain or attempt to obtain controlled substances/medications from another prescriber for a condition and/or controlled substances currently prescribed by Dr. B Psychiatry Consult. If a controlled substance is prescribed by a non Dr. B Psychiatry Consult, PC prescriber, including a dentist, an ER, or a hospital, I will communicate with my Dr. B Psychiatry Consult, PC prescriber, who may reassess my treatment plan.
14. I will safeguard my medication from loss or theft. If my medicine is lost or stolen, I understand that it is within my prescriber's discretion whether or not to replace or refill it.
15. I agree that I will use my medicine in the dosage and frequency as ordered by my prescriber. Early refills may be refused if I took more than the prescribed dosage without instruction from my prescriber.
16. I will tell my prescriber about any new medical conditions, medications, and side effects I have from my medications. I will also tell my prescriber if I stop using any medications.
17. I will update my pharmacy and contact information in a timely manner.
18. I agree that I will participate in random and unannounced urine drug screen tests when my prescriber asks me. If I refuse to provide a sample for this test, my prescriber may choose to stop prescribing controlled medication to me.
19. My prescriber has spoken with me about potential psychological and/or physiological dependence on controlled substances. I know that some people may develop a tolerance to medication and need to increase the dose, which makes them more likely to become dependent. Dependence may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.
20. For Women Only: I understand that if I take this medication while pregnant, my baby may be addicted to it at birth or have withdrawal effects. Some medications may cause long term neurobehavioral problems to the baby. Medications may also be present in breast milk. I agree that if I become or plan to become pregnant and/or breast feed while taking this medication, I will immediately inform my prescriber and obstetrician.
21. I understand that pain management is outside Dr. B Psychiatry Consult, PC's scope of practice. My Dr. B Psychiatry Consult, PC provider may choose to transfer my care to a pain management specialist for chronic or acute pain. I understand that it is my responsibility to follow through with any pain management referral in a timely manner, and that my Dr. B Psychiatry Consult, PC provider may decline to prescribe controlled substances for pain after referring me to a pain management specialist.
22. I agree to follow the elements of this Agreement, which have been fully explained to me. All of my questions and concerns regarding this Agreement have been answered and a copy of this Agreement has been given to me.

I understand that if I do not follow this Agreement, my prescriber may choose to no longer prescribe controlled substances to me, and I could be terminated from Dr. B Psychiatry Consult, PC as a patient.

Patient Signature: _____ Date:_____