Controlled Substance Agreement

INTRODUCTION

The purpose of this Agreement is to provide information about certain medications you may be prescribed by the providers at this center. This is to help both you and your provider comply with the law regarding controlled pharmaceuticals.

RECITALS

- I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.
- I understand that if I break this Agreement, my provider may stop prescribing me certain medication and/or release me from the practice. In this case, my provider will taper me off of the medication over a period of several days as necessary to avoid withdrawal symptoms. Also, a drug dependent treatment program may be recommended.
- I will communicate fully with my provider about the character and intensity of symptoms, the effect of the symptoms on my daily life, and how well the medication is helping to relieve my symptoms.
- I will not use any illegal controlled substance, including marijuana, cocaine, etc. I will not share, sell, or trade my medication with anyone. I will not attempt to obtain any controlled medication including benzodiazepines, stimulants, or antianxiety medication, to treat the same symptoms from any other provider.
- I understand that lost or stolen medication will not be replaced under any circumstances.
- I agree that refills of my prescriptions for controlled medication will be made only at the time of an office visit or during regular office hours. No refills will be made during non-business hours.
- I agree to submit to a saliva or urine test if requested by my provider to determine my adherence with prescribed treatment.
- I agree that I will use my medication at a rate no greater than the prescribed rate. I understand that the use of my medication at a greater rate will result in my being without medication for a period of time.

CONTROLLED SUBSTANCE AGREEMENT ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. I have had the opportunity to discuss any questions regarding this document.

Patient Name _____ Patient Signature _____ Date _____

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

Name _____ Relationship _____ Signature _____ Date _____

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