Patient Name: _____ Patient DOB: __ /__ /_____

(Please Print Clearly)

PATIENT CONTRACT BETWEEN BARNABAS BEHAVIORAL HEALTHCARE, LLC AND PATIENT WHO ARE PRESECRIBED ANY CONTROLLED SUBSTANCES

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (Narcotic pain medicines) benzodiazepine (Xanax, Klonopin), and stimulants (Adderall, Ritalin, etc.) barbiturate sedatives (Ambien, Halcion) is controversial because it is not certain whether they help patients over the long term. Patients who are prescribed these drugs have some risk of developing an addictive disorder developing or suffering a relapse of a prior addiction. The extent of this risk is not certain.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason, we require each patient receiving long-term treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician/nurse practitioner whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your condition.

1. All controlled substances must come from a physician/nurse practitioner in this office. My controlled substances will come from the physician/nurse practitioner whose signature appears below, or during his or her absence, by the covering prescriber unless specific authorization is obtained for an exception.

   Exception:_____

2. I will inform any physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.

3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform all my providers in advance. The pharmacy I am selecting is:

   _____ (pharmacy)_____(phone)

4. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

5. I agree that my prescribing physician/nurse practitioner has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide health care for purposes of maintaining accountability.

6. I will not allow anyone else to have, use, sell, or otherwise have access to these medications.

7. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

8. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.

9. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.

10. I will cooperate with unannounced urine or serum toxicology screens as may be requested.

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(Please Print Clearly)

11. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

12. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

13. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, I will be required to complete a statement explaining the circumstances. At that time, a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year I will possibly be discharged from the practice.

14. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to the appropriate date.

15. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

16. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician/nurse practitioner or referral for further specialty assessment.

17. ***I will keep my scheduled appointments in order to receive medication renewals. No refills will be given out by phone, fax, at night or on weekends.

18. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on whether my physician/nurse practitioner believes that the medication usage benefits me.

19. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal, and over dosage.

20. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of the terms.

21. I am aware that attempting to obtain a controlled substance under false pretenses is illegal and I will be terminated from treatment at Barnabas Behavioral Healthcare, LLC.

_____ _____

Patient Signature Date

_____ _____

Physician/ARPN Signature Date