ROUND ROCK PSYCHIATRY
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CONTROLLED SUBSTANCE AGREEMENT:

The following agreements are made between the Patient and Physician, as identified above, and outlines the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. This Controlled Substance Agreement relates to my use of any and all prescription medication(s) to manage my condition as prescribed by my physician.

2. All medication(s) and prescriptions for the treatment of my condition will be obtained from **only** my physician.

3. Medication(s) for the management of my condition will be provided by my physician so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my physician's care and treatment.

4. Discharge from my physician's care and treatment may be **immediate** for any criminal behavior.

5. I will use the medication(s) exactly as directed by my physician.

6. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued by my physician. Please keep in mind that should Dr. Calzada prescribe a Benzodiazepine it will be with the philosophy of using the lowest effective dose for the shortest amount of time that he deems medically necessary.

7. Use of illegal substances, alcohol, and other mood altering drugs can lead to dangerous side effects. I agree to submit to urine and / or blood screens to detect the use or non-use of non-prescribed and prescribed medication(s) at any time and without prior warning on less than 24 hour notice. Any evidence of use of illegal substances may lead to discontinuation of the medication(s).

8. Dr. Calzada may at any time choose to discontinue the medication(s) for the treatment of my condition typically based off a risk versus benefit analysis.

9. I will disclose to my doctor all other medication(s) that I take at any time, prescribed by any doctor other than my physician.

10. I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.

11. I will not share, sell or otherwise permit others, including my family and friends to have access to my medication(s).

12. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and / or prescriptions may not be replaced.

13. I agree not to obtain or seek to obtain any other medication(s) from any other source without first contacting my physician. Information that I have been receiving other medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of the medication(s) and treatment.

14. I understand that the State of Texas tracks information provided by pharmacies regarding all controlled substance prescriptions. My physician may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.

15. I will notify my physician's office during office hours at least five (5) business days in advance before running out of medication(s) so the appropriate refills can be made.

16. I understand that refills **will NOT** be ordered before the scheduled refill date even if my medication(s) runs out. Controlled Substances may be refilled no earlier than 30 days following the most recent prescription has been sent to the pharmacy. When traveling, arrangements must be made in advance of planned departure date as early refills will not be provided.

17. If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the reasonable discontinuance of the medication(s).

18. I recognize that my condition represents a complex problem which may benefit from other therapies (i.e., physical therapy, psychotherapy, alternative medical care, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommend by my physician to achieve increased function and improved quality of life.

19. I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).

20. I must keep all follow-up appointments as recommended by my physician or my treatment and / or medication(s) may be discontinued.

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of nontreatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.

3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

4. I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substances Agreement.

DATE: _____ TIME:_____

PATIENT SIGNATURE: _____

PATIENT PRINT NAME: _____

WITNESS/**PHYSICIAN**: _____