PROVIDERS FOR HEALTHY LIVING

Child, Adolescent, and Adult Psychiatry & Therapy Services

PATIENT AGREEMENT FOR CONTROLLED SUBSTANCE THERAPY

Initial each of the following and sign below to indicate your agreement/understanding:

_____ I agree that _____ will be the only provider prescribing _____, a potentially addictive medication, and that I will obtain all of my prescriptions for this medication at one pharmacy. The exception would be an emergency situation. Should such occasions occur, I will inform my prescribing provider as soon as possible.

_____ I understand the importance of taking this medication at the dose and frequency prescribed. I agree not to increase the dose of this medication without first discussing it with my prescribing provider. I understand that expected prescription refill dates will be used to promote optimal use of this medication, and early refills will NOT be provided.

_____ I understand that potentially addictive medications cannot be prescribed to me if I am using alcohol or drugs, if I have an active drug or alcohol use disorder, or if I am misusing my own or someone else's potentially addictive medication.

_____ My prescribing provider may require random urine testing as a matter of routine monitoring.

_____ I will attend all reasonable appointments, treatments, testing, and consultations as requested by my prescribing provider. I will pursue other consultations/ management strategies, as necessary.

_____ I understand that I should check with my prescribing provider or pharmacist before taking other medications, including over-the-counter and herbal products.

_____ I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my prescribed medication. I agree not to give or sell my prescribed medication to any other person. I acknowledge that my prescribing provider will NOT replace any medication shortfall.

_____ I consent to open communication between my doctor and any other health care professionals involved in my medical care, such as pharmacists, other prescribing providers, emergency departments, etc.

_____ I understand that if I break this agreement, my prescribing provider reserves the right to stop prescribing potentially addictive medications for me.

_____ If a stimulant medication is prescribed to me, I understand and agree that I must complete the ADHD skills therapy (either group or individual) on or before _____ or this medication will no longer be prescribed until the therapy sessions have been completed.

Patient Name: _____

Patient Signature: _____

Date: _____

Prescribing Provider Name/Signature: _____