Controlled Substance Treatment Agreement

Patient Name	
Date	

I freely and voluntarily agree to accept this treatment agreement as follows:

1. Controlled substances may be prescribed for certain psychiatric conditions. Controlled substances carry risk for physical and psychological dependence or misuse. Controlled medications are often not indicated for long term use and in some cases may exacerbate certain psychiatric conditions. Your clinician will determine the appropriate medication, dose and duration for your condition. The medication I am prescribed is described below.

Medication name:	
Diagnosis:	
Treatment goal:	

2. I understand that the initial visits will include substance use and behavioral health evaluations, drug screening tests, an explanation of how the medication works, review of the treatment agreement, physical examination and laboratory testing.
3. I understand that I may not be prescribed controlled medication at my initial visit.
4. I agree to participate in visits as often as once every 1-4 weeks based on how well I am responding to treatment and per the advice of my providers.
5. I understand that I will be offered counseling. I understand that in certain circumstances my provider may require counseling as part of my treatment plan.
6. I agree to provide proof of attendance for counseling when and if requested by my providers.
7. I understand that I may also be asked to participate in group treatments which may occur in person or may occur via a telehealth platform.
8. I agree to keep my scheduled appointments and notify the office in advance if I have to reschedule. I also agree to arrive on time for my appointments and that if I arrive late I may not be able to be seen.
9. I agree that it is my responsibility to make follow up appointments with my providers in a timely manner.
10. I agree to pick up my prescription ONLY at the following pharmacy:

Pharmacy Name:	
Pharmacy Address:	
Pharmacy City:	

11. I agree that my medication can only be given to me through regular visits with my provider. If I miss a visit this may result in me going without medication until my next scheduled visit.

12. I understand only my provider will refill my medication, controlled substance requests will not be filled outside of regular appointment and office hours. There is no on-call, evening, weekend nor emergency services provided.

13. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that this medication is intended only for me and cannot be given to anyone else. I understand that if my medication is inadvertently taken by a child it could result in serious injury and death. I understand that any child with such ingestion or exposure must be immediately evaluated in an Emergency Department.

14. I understand that lost or stolen medication will not be replaced.

15. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is illegal and a serious violation of this agreement and may result in my treatment being terminated without any recourse for appeal.

16. I understand that if dealing, stealing, or any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my prescription is filled that the behavior will be reported to this office and could result in my treatment being terminated without any recourse.

17. I agree that I will inform my providers of all medications that I am taking. The current medication list that I have provided is accurate at the time and includes all medications that I take. If I start taking other medication, I will inform my provider.

18. I agree not to take any medications not prescribed to me. I understand that mixing my medication with other prescription medications can be dangerous.

19. I agree to take my medication by the route and dose that my provider has instructed me and not to alter the way that I take my medications without first consulting my provider.

20. I expect to provide urine/saliva/blood samples at every visit and whenever randomly requested by a health care staff member. Failure to provide a urine/saliva/blood sample may result in the withholding of my prescription. I understand that urine/saliva/blood drug tests help assist my providers with an appropriate treatment plan for me.

21. I understand that if I want to stop my medication or if my providers decide that it needs to be stopped for whatever reason, I need to work with my providers and give them advanced notice so that they can safely discontinue the medication.

22. I understand that I may be referred to a higher level of care such as an intensive

outpatient or partial hospitalization program if it is found that I need additional treatment or need treatment in a different setting.

23. I understand that providers honor confidentiality and that I agree to not disclose the identities of the other behavioral health program participants.

24. I understand that violations of the above conditions may be grounds for termination of treatment.

25. I understand that this agreement is void if the prescribing provider decided this program is not appropriate for me.

I have read this controlled substance treatment agreement or have had it read or explained to me and I understand and agree to its conditions as outlined above.

Patient Signature: _____ Date:_____

Provider Signature:_____ Date:_____