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Controlled Substance Contract

Patient Name: _____

I agree to the following:

- I understand that controlled substances are prescribed to me as part of my treatment plan for my mental health condition(s). I acknowledge the potential risks associated with these medications, including: addiction, misuse, overdose, and/or side effects and agree to work closely with my provider to manage these risks.
- I agree to comply with monitoring procedures, as required by my provider to ensure I am using my medications appropriately.
- I will attend all follow-up appointments with my provider to discuss my treatment progress, side effects, and continued need for medication.
- I will inform my provider about any other medications, including over-the-counter drugs, herbal supplements, or recreational substances that I am using.
- I agree to take the medication exactly as prescribed by my provider, including the correct dosage, frequency, and timing.
- I understand that I should not share, sell, or exchange my prescribed medications with others. I understand that doing so is a felony crime.
- I acknowledge that the provider will assess my condition and prescribe medication based on professional judgment and clinical guidelines.
- I will not increase my medicine until I speak with my provider or medical assistant.
- I will not expect refills if I miss appointments or if my provider is unable to verify the ongoing need for the medication.
- I accept that lost and/or stolen prescriptions will not be replaced. I am responsible for safeguarding my medications.

- I am responsible for safely storing my medications and will keep them in a secure place to prevent misuse by others, especially children or individuals who may be tempted to misuse them.
- Medication change and/or dosage changes will not be made outside of an appointment unless previously discussed.
- I understand that using alcohol or illicit drugs could intensify the effects of my medications.

Discontinuation of Medication

I understand that my provider may discontinue prescribing controlled substances to me at any time for the following reasons:

- Engaging in illegal activity, including drug diversion.
- Misuse, non-compliance, or failure to follow the treatment plan.
- Experiencing significant adverse side effects or risks to my health.
- Requesting early refills or demonstrating unusual behavior concerning my medications.

If medication is discontinued, I agree to work with my provider to safely taper off the medication and explore alternative treatment options.

Refills

Refills will be made only during regular office hours – Monday through Friday 8:00AM - 6:00PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I will not come to the clinic for my refill until I am called by the nurse.
I must keep track of my medications. No early or emergency refills may be made.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance (for example, a dentist, a doctor from the Emergency Room, or another hospital, etc), I must notify the clinic as soon as possible.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.
I have talked about this agreement with my doctor and I understand the above rules.

_____

Patient Signature Date