AR PSYCHIATRIC AND COUNSELING CENTER

Controlled Substance Policy

I, (name) _____ (DOB) _____, understand that my provider is prescribing a controlled substance medication as part of my treatment plan. I may be treated with medications such as benzodiazepines, stimulants, and or partial opioid agonists (like buprenorphine). These medications may impair my alertness, reflexes, coordination, and judgment. These types of medications are controlled and monitored by local, state, and federal agencies. These medications can be highly effective when taken as directed under medical supervision but have the potential for abuse and misuse.

I understand that psychological dependence and addiction to controlled substances can occur and are a risk of treatment. If this happens, I will follow my physician's guidance and participate in any recommended treatment programs, which may include medical detoxification and psychological counseling on substance misuse.

I AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

- I will take the medication exactly as prescribed, and I will not change the medication dosage and/or frequency without my physician's approval.
- I agree not to share my medication with anyone.
- I will keep regularly scheduled appointments with my physician. If refills are needed between office visits, I will call the office staff at least **5** days before your medication runs out.
- I understand that **no** early refills of medication will be authorized.
  I understand that I will **not** be given a dosage higher than the FDA guideline's recommended dosage. I am currently on a higher dosage than the FDA's maximum recommended dosage, then my provider may decide to reduce the dosage or change the medication.
- I will not accept or seek controlled substance medication from any other physician or health care provider outside of this practice while being prescribed controlled medication.
- I understand that I must keep my provider informed of all medication that is prescribed to me outside of this practice.
- I understand that office staff is not permitted to refill controlled medications without provider approval.
- I understand that my controlled prescription will only be sent to **one** pharmacy and cannot be transferred or sent to multiple locations
- I understand that lost, stolen, or misplace prescriptions or pills will **not** be replaced.
- I agree that I will not use any illegal drug(s) while receiving care and medication from this practice.
- I agree and understand that my physician may ask a random urine drug testing. If I fail to obtain a drug screen when asked or if the results are inconsistent, I may forfeit the right to continue receiving controlled medication.
- I understand that I should not mix benzodiazepine (anti-anxiety) medications with alcohol and/or opiate (pain)medications. There is a major risk of a decreased respiratory rate that can lead to death when mixing these medications with other substances.

I have read this agreement. I fully understand the consequences or violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Signature: _____ Date: _____