PATHWAY
PSYCHIATRY & COUNSELING CENTER

Patient/Provider Controlled Medication Agreement

The purpose of this agreement is to be certain that long-term controlled substances are prescribed in the safest, most effective manner in compliance with current law. Utilization of controlled substances over a long period of time may be medically useful, but may carry the risk of dependency, addiction, and loss of effectiveness. You must understand and agree to the following terms in order for us to enter with into a prescribing relationship. I understand that breaking the terms of this agreement will mean my doctor will no longer prescribe controlled substances for my condition. I understand that violating the terms of this agreement could result in discharge from the practice**. Please initial next to each number.**

_____1. The goal of treatment will be established with my provider and will focus on improving function, not total symptom elimination.

_____2. I will not obtain controlled substances from any other provider, emergency room, or urgent care facility without notifying my prescribing provider.

_____3. I will not share, sell, or let others have access to my controlled medications.

_____4. I will not alter a prescription, use deception to obtain a prescription, or provide prescription medicine to anyone else. I understand that any such activity not only violates this agreement but is also a felony offense.

_____5. My provider will decide how often I need to be seen for office evaluation and assessment. My treatment will be continued only if I return to the office for these visits. I must schedule these visits so that I do not run out of medications. I will not ask for early prescriptions for renewals. The assessment interval shall not exceed 3 months in any case.

_____6. I understand that if I use my medication at a greater rate than it is prescribed for that I will run out of my medication for a period of time and that I may experience withdrawal or other dangerous effects. If my prescription is lost or stolen, I understand that I should file a police report.

_____7. I understand that controlled substances are used as a component of a total treatment plan to control symptoms. I agree to participate in any and all aspects of this treatment plan that my provider feels would be in my best interest.

_____8. I will not adjust any dosage of medication unless specifically directed by my provider.

_____9. My provider will evaluate the effectiveness of my treatment plan on an ongoing basis. I agree to communicate fully the effect of my prescription on my symptoms.

_____10. If controlled medications are not effective, I agree that discontinuing them under my provider's direction is an appropriate treatment option.

_____11. I agree to notify my provider of all other medications and substances I am taking. Sedatives, alcohol, and street drugs should not be taken with controlled prescriptions.

_____12. Monitoring of blood or urine of patients taking controlled substances will be a part of my care, I agree to provide samples when asked. I understand that my provider may wish to dedicate an appointment solely for this purpose.

_____13. I agree to provide photo identification and comply with any other office policies for retrieving printed prescriptions.

_____14. I understand that controlled medications may be harmful during pregnancy and agree to notify my provider if I become pregnant.

I have read and understand this agreement and have had the opportunity to have all questions answered to my satisfaction. I agree to the use of controlled substances for my condition under the terms of this agreement. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor will be treating me based on the terms of this agreement. I understand that breaking the terms of this agreement will mean my doctor will no longer prescribe controlled substances for my condition. I understand that violating the terms of this agreement could result in discharge from the practice.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____