Killeen Psychiatry — Controlled Substance Agreement

Patient name	Date of birth	Date

1. Contract for Controlled Substance Prescriptions

Controlled substance medications (i.e., benzodiazepines and stimulants) are very useful but have potential for misuse; therefore, they are controlled by local, state and federal government. They are intended to improve function and/or ability to work, not simply to feel good. Because I am receiving such medications I agree to the following requirements. ALL BOXES MUST BE CHECKED:

2. Medication Responsibility

Checking the boxes demonstrates I understand & agree:

- ☐ a. I am responsible for my controlled substance medications. (required)
- ☐ b. If the medication is lost, misplaced, or stolen or if I take more than prescribed medications will not be replaced. (required)

3. Single Prescriber & Hospital Exception

Checking the boxes demonstrates I understand & agree:

- ☐ a. I will not request or accept the same controlled substance medication from any other provider or while I am receiving the same medication from Killeen Psychiatry. (required)
- ☐ b. If I do this - it is illegal as well as dangerous to my health. (required)
- ☐ c. The only exception to this is when I am admitted as a patient to a hospital. (required)

4. Treatment Goals & Health Habits

Checking the boxes demonstrates I understand & agree:

- ☐ a. that the main treatment goal is to improve my ability to function and/or work. (required)
- ☐ b. I am being given potent medication to help me reach that goal. (required)
- ☐ c. to help myself by following better health habits. (required)
- ☐ d. to non use of street drugs. I understand that using “street drugs” will impact my progress and counteract with any prescribed medications. (required)
- ☐ e. that continued use after warning can be cause for my care to be terminated immediately from Killeen Psychiatry. (required)

5. Refill Requirements

Checking the following boxes demonstrates I understand refills of controlled substance medication:

- ☐ a. will not be made if I “run out early” -- I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. (required)
- ☐ b. will not be made as an “emergency" (such as a Thursday afternoon because I suddenly realize that I will run out tomorrow and the office will be closed). (required)
- ☐ c. I will call at least seventy-two (72) hours in advance if I need assistance with a controlled medication prescription. (required)
- ☐ d. No controlled medications will be ordered when the office is closed. (required)

6. Appointments & Monitoring

Checking the boxes demonstrates I understand and I agree:

- ☐ a. to follow my treatment plan as discussed at time of appointment (required)
- ☐ b. to keep my appointments (including follow-ups and referrals) (required)
- ☐ c. to permit urine drug screening and / or pill counts without prior notice. (required)

7. Violations & Disclosure

Checking the boxes demonstrates I understand & agree:

- ☐ a. if I violate any of the above conditions, my controlled substance prescription and/or treatment with Killeen Psychiatry, may be terminated immediately. (required)
- ☐ b. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to other healthcare providers, medical facilities, pharmacies and other authorities. (required)

8. Medication Interactions

Checking the boxes demonstrates I understand & agree:

- ☐ a. all medications have the potential to interact with one another, including controlled substance medication. (required)
- ☐ b. to inform my provider if I start a new medication or I have a dose change of one of my medications prior to refilling or requesting a refill of my controlled substance medication. (required)

9. Please note: the Texas Prescription Monitoring Program (PMP) will be evaluated each month prior to prescribing refills.

I have read this contract and fully understand its content. In addition, I fully understand the consequences of violating this contract.

Date: (required)
MM/DD/YYYY

_____

Signature

Signature of patient or legal representative _____ Date _____

Printed name _____

If signing for the patient, your relationship to the patient _____