

Controlled Substance Agreement

Medication Name: _____ (“Controlled Substance Medication”)

There are Florida and Federal laws governing the prescribing of controlled substances. Controlled substances include all narcotics (such as hydrocodone, oxycodone, hydromorphone, morphine), sleeping aids (such as zolpidem, zaleplon), benzodiazepines (such as alprazolam, diazepam, lorazepam), and ADHD medications (such as methylphenidate, amphetamines). To comply with these laws, I acknowledge and agree to the terms of this Controlled Substance Agreement (“Agreement”).

I, _____, understand I have been prescribed a controlled substance (“Controlled Substance Medication”) for my diagnosis of _____. I agree to the terms set forth in this Agreement and understand that compliance with this Agreement is required at all times to continue to receive Controlled Substance Medication(s).

1. Most controlled substance medication prescriptions can only be written for a 30-day supply. I will take the Controlled Substance Medication only at the dose and frequency prescribed. I understand that taking Controlled Substance Medication more often than prescribed will result in a time period without medication.
2. It is my responsibility to keep my medication safe and secure. Lost, unsecured, or stolen medications will not be replaced and could pose a risk to others. I Care Psych is not responsible for any Controlled Substance Medications that have been misplaced, lost, or stolen. Controlled Substance Medications will not be refilled before the renewal date.
3. I agree that only I Care Psych will prescribe me with the Controlled Substance Medication. I will inform my I Care Psych provider of any controlled substance(s) prescribed by other providers and will timely notify my I Care Psych provider regarding any changes to controlled substances I am prescribed or taking. I confirm that I am not currently receiving controlled substances from any other sources which I have not disclosed to my I Care Psych provider.
4. It is critical for my health that all of my treating providers are aware of all medications I am taking. Failure to inform health care providers (including dental providers) of medications I’m currently taking, including Controlled Substance Medication, can result in negative treatment outcomes and/or overdose.
5. For coordination of care purposes, I agree to notify my I Care Psych provider without delay if I am currently, or intend to in the future, receive similar psychiatric treatment involving controlled substances from any other source. I will instruct my other health care providers to confer with my I Care Psych provider regarding any changes or need for additional controlled substance medication. If it is discovered that other providers are prescribing controlled substance medications for me, my I Care Psych provider reserves the right to discontinue prescribing medications and/or discharge me from treatment at I Care Psych.
6. I understand that suddenly stopping Controlled Substance Medication may cause very serious withdrawal symptoms including seizures, panic attacks, hallucinations, and psychosis. I will comply with my treatment plan and prescription to avoid these symptoms.
7. To ensure my health and proper coordination of care, it may be necessary for I Care Psych to access or disclose my health information to other providers providing treatment to me. I specifically authorize I Care Psych to access and disclose my health information for treatment and care coordination purposes (including medication reconciliation) to my other health care providers, including without limitation disclosure of mental health diagnosis/treatment information, substance use disorder diagnosis and treatment information (if applicable), all medications prescribed, and any other treatment information need to ensure proper coordination of care. This may include disclosure to any substance use disorder treatment facilities that provide treatment to me, should I have or develop a substance use disorder.
8. I will consent to random drug testing as my treatment provider deems necessary and understand that routine blood work and random urine drug screens may be part of my treatment plan. I agree to have them done on the same day my I Care Psych provider requests it.
9. I understand that mixing Controlled Substance Medication with alcohol or other drugs can be dangerous and even lethal. Thousands of deaths have occurred among persons mixing benzodiazepines, alcohol, opioid narcotics, painkillers, and other drugs. I agree not to mix my Controlled Substance Medication

- with such substances. If I am prescribed Opioids, Benzodiazepines cannot be prescribed due to the increased risk of respiratory depression with the combination of these two controlled substances.
10. For my own safety, I agree that I will only take my Controlled Substance Medication as prescribed. I further agree to comply with all warnings and instructions contained on each medication label.
 11. I will not sell, distribute, or give any of my Controlled Substance Medication to any other individuals.
 12. I will keep and be on time for my scheduled appointments and comply with my treatment plan, which may include therapy, patient education, or a relapse prevention program.
 13. I agree to conduct myself in a courteous manner during interactions with my I Care Psych provider and their staff.
 14. I understand that for my medication to be refilled/continued, I must see my I Care Psych provider as recommended/requested (at least every three (3) months). Refills will only be provided during regular business hours and will NOT be provided at night or on weekends.
 15. I understand that I must provide at least 72 business hours prior notice of my need for a refill and am required to come into the I Care Psych office to pick up a written prescription (prescriptions for Controlled Substance Medication will not be phoned or faxed to pharmacies). I will be required to show proof of identity prior to receiving the prescription.
 16. All Controlled Substance Medication should be filled at the same pharmacy, when possible. My pharmacy is (name/phone #): _____
 17. **I agree to call 911 or go immediately to an emergency room in the event of an emergency medical event or a situation that could reasonably be expected to develop into an emergency, including potential overdoses or severe adverse reactions to Controlled Substance Medication.**
 18. I Care Psych has the right to discontinue controlled substance medications and discharge me from care if any of the following occur:
 - a. I trade, sell, misuse, or share medication with others.
 - b. I fail to comply any part of this Agreement;
 - c. I do not go for blood work or urine tests requested;
 - d. My blood or urine shows the presence of medications that my provider is not aware of, the presence of illegal drugs, or does not show medications that I am prescribed;
 - e. I get controlled substances from sources other than I Care Psych providers;
 - f. I exhibit any aggressive behavior toward I Care Psych providers or staff; or
 - g. I consistently miss appointments.
 19. It is a crime to obtain narcotics under false pretenses. This could include getting medications from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). I understand that I may be subject to legal action for engaging in such activities, and that privacy laws may permit law enforcement to get access to my records during any such criminal investigation.

Acknowledgement

I confirm that I have reviewed this Controlled Substance Agreement and discussed this Controlled Substance Medication, the reason for prescribing it, its purpose and intended results, and its possible risks, side effects and contraindications with my I Care Psych provider, and my questions have been answered. I confirm that the method for administering the medication, dosage range when applicable, potential drug interactions, alternative treatments and behavioral health or other services used to complement the use of medication, have been explained to me. I have discussed and am aware of the risks associated with abruptly stopping this medication. **I understand that failure to comply with this Controlled Substance Agreement will result in the tapering and/or discontinuation of the Controlled Substance Medication, and that my I Care Psych provider cannot continue to prescribe me Controlled Substance Medication if I fail to comply with the terms of this Controlled Substance Agreement.**

Patient/Guardian Signature

Date

Printed Name

Relationship to Patient