Controlled Substance Agreement

My physician and I have a common treatment goal to improve my ability to function and/or work. In consideration of that goal, I am being treated with medications such as benzodiazepines or barbiturates. These medications may impair my alertness, reflexes, coordination and judgment. The use of these types of medications is 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 of abuse and misuse.

- I have been informed that psychological dependence and addiction to controlled substances can occur and are a risk of treatment. If this happens, I will follow my provider's guidance and participate in any treatment programs recommended, which may include medical detoxification, psychological counseling pertaining to substance misuse.
- I agree to inform my provider if I am diagnosed with or treated for a substance use problem.
- I have never been involved in the illegal sale, possession or transportation of controlled substances.
- I understand that the giving or sale of my prescription medication to any other person is illegal and **WILL** result in my dismissal from Suburban Psychiatric Associates, LLP as well as being reported to law enforcement officers.
- I have been informed by my provider and I understand I should not consume alcohol with taking these types of medications.
- I am aware that my provider has access to, and will be reviewing my patterns of filling prescriptions through the *New York State Prescription Monitoring Program*.
- I take full responsibility for the consequences of driving a motor vehicle, operation of machinery or doing any other activity in which alertness, reflexes, coordination and/or judgment are necessary.
- For women of childbearing age: I am not pregnant.

I AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

1. *I will follow the treatment plan that my provider and I have agreed upon.*
2. *I agree to always be truthful with all my provider and my other physicians regarding my history, illness, and use of medication.*
3. *I will report any suspected side effects to my provider immediately.*
4. *I understand that my provider is not obligated, nor will he/she automatically refill prescriptions for controlled medications that I have been receiving from another physician.*
5. *I will not ask for, nor accept duplicate controlled substance medications or prescriptions from any other individuals or physicians while I am receiving such medications from any provider at Suburban Psychiatric Associates, LLP. This could endanger my health. If another physician prescribes a controlled substance medication to me, I will notify my Suburban Psychiatric physician and the physician prescribing the medication immediately that I am currently receiving a controlled medication from another prescriber.*
6. *I will take the medications as directed. If I use my medication up sooner than prescribed, lose my prescription or medication, or if my medication is stolen, I understand the providers at Suburban Psychiatric Associates, LLP will not refill my medication until it is time for the*

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scheduled refill.

7. *I will bring the unused portion of my medication to the office for a medication count if requested by my provider.*
8. *In the event that my prescription needs to be changed to another medication, I understand I may be asked to return the remaining portion of the prior prescription for disposal.*
9. *I understand my medication dosage may need to be increased or decreased depending upon my condition. I will not adjust my medication myself and understand if I need more medication due to a worsening of my condition, I must see my psychiatrist to be re-evaluated before my medication will be increased.*
10. *I understand that stopping my medications abruptly maybe dangerous and lead to withdrawal symptoms, including increased anxiety, sweats, tremors, nausea, vomiting and possible seizures, hallucinations or confusion. If medications need to be discontinued, I will follow my psychiatrist's supervision.*
11. *I will submit to drug testing if requested, including urine, saliva or hair testing.*
12. *I authorize Suburban Psychiatric Associates, LLP and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled medications. I authorize Suburban Psychiatric Associates, LLP to provide a copy of this agreement to my pharmacy. I also authorize my pharmacy to provide records documenting prescriptions that I have received to Suburban Psychiatric Associates, LLP, if requested. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.*
13. *I am responsible for keeping track of the amount of medication, and will plan ahead for refills in a timely manner, so I will not run out of my medication. I understand that these types of medications will only be refilled during regular business hours by Suburban Psychiatric Associates, LLP.*
14. *For women: am not pregnant and agree to utilize birth control at all times while taking these types of medications. Should I become pregnant, I agree to notify Suburban Psychiatric Associates, LLP. I will accept the risk to my baby and myself if I should use these medications while pregnant.*

My signature below means I have read and understand the terms of this agreement and have had questions answered to my satisfaction. I understand if I violate this agreement, my controlled substance prescriptions and/or treatment will be terminated immediately and I will be dismissed from Suburban Psychiatric Associates, LLP.

Patient Name (Print):_____ MRN: _____

Patient Signature:_____ Date: _____