Controlled Substances Contract

Controlled substance medications (i.e., benzodiazepines, stimulants, hypnotics, etc.) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state and federal government(s). As a patient of Rural Psychiatry Associates (RPA) you agree and understand the following (initial each section):

Patient's Initials

_____ 1) I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if "I run out early," I understand this medication will not be replaced regardless of the circumstances.

_____ 2) Refills of controlled substance medications:

A. Will be made only during regular office hours during a regular scheduled appointment.
B. Will not be made if "I lost my prescriptions", "ran out early", or "misplaced my medication". I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____ 3) Due to respiratory suppression risks when individuals take opioid medication(s) with benzodiazepine medication(s), RPA providers will not prescribe benzodiazepines if a patient has been prescribed opioids by an outside provider.

_____ 4) Due to risks associated with co-administration of prescribed medications, RPA providers are recommended against prescribing controlled substances to patients who report or are known to be using Cannabis or other controlled substances.

_____ 5) I agree to comply with urine drug testing and pill counts at my scheduled appointments as requested, thereby, documenting the proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.

_____ 6) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual, or the simultaneous use of non-prescription illicit (illegal) and or legal drugs (medical marijuana), I may also be reported to other physicians, pharmacies, medical facilities and the appropriate authorities.

_____ 7) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from the RPA clinic.

_____ 8) I agree to keep my scheduled appointments, adhere to the payment policy outlined by the clinic and conduct myself in a courteous manner while in the clinic.

_____ 9) I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

_____ 10) I agree not to obtain medication from any doctors, pharmacies or other sources without telling my treating provider.

_____ 11) I agree to take my medication as my provider has instructed and not to alter the way I take my medication without first consulting my provider.

_____ 12) I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine, and other medical/non-medical addictive substances.

_____ 13) I agree to fill all of my controlled medications at an in-state pharmacy. I will list my pharmacy of choice and understand that I must utilize this pharmacy. If at any time, I choose to change my pharmacy, I will notify RPA at my scheduled appointment. All prescriptions will be sent electronically. **RPA will not use a pharmacy that cannot accept electronic prescriptions. It is the responsibility of the patient to ensure that the pharmacy that they have selected is capable of receiving prescriptions electronically.**

_____ 14) I understand that RPA utilizes the state's prescription drug monitoring database and will monitor my prescription history via this source.

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of RPA in regards to the controlled substances my physician is prescribing.

Patient Name (print) _____ Date _____

Patient / Guardian Signature _____

*By signing your name electronically, you are agreeing that your electronic signature is the legal equivalent of your handwritten signature.

RURAL PSYCHIATRY ASSOCIATES