Controlled Substance Agreement

Patient Name: _____ **Date of Birth:** _____

This agreement is made between **Huntsville Neuropsychiatric Services** and the above-named patient for the purpose of managing and monitoring the appropriate use of **controlled substance medications** prescribed for the treatment of a diagnosed medical condition.

Controlled substances include medications such as opioids (e.g., hydrocodone, oxycodone), benzodiazepines (e.g., lorazepam, clonazepam), stimulants (e.g., amphetamine, methylphenidate), and other drugs regulated by law due to their potential for **dependence, misuse, and abuse**.

Patient Responsibilities

1. **Medication Use**
   - I agree to take the medication exactly as prescribed.
   - I will not increase the dose or frequency without approval from my provider.
   - I will keep my medications in a secure location and out of the reach of others, especially children.
   - I understand that giving or selling my medication to another person is illegal and may result in criminal prosecution and termination of care.
   - I understand that combining controlled substances with alcohol, illicit drugs, or other sedatives (e.g., sleep aids) is dangerous and may result in serious harm or death.
2. **Disclosure of Other Medications or Conditions**
   - I agree to inform my provider of **all medications** (prescription, over-the-counter, herbal) and **all medical conditions**, including physical health, mental health, or substance use history.
   - I understand that there are certain psychiatric medications, including controlled substances, that may carry increased risk when combined with underlining medical conditions such as high blood pressure, heart problems, or other physical health concerns. For my safety and to ensure the effectiveness of my treatment, I agree to inform my psychiatric provider of any current or new medical conditions, including visits to other medical specialists (e.g. cardiologist, etc.), hospitalizations, or changes in my overall physical health.

_____ **PATIENT INITIAL THAT YOU HAVE READ ALL THE ABOVE**

CONTINUE ON BACK

3. **Refills and Appointments**
    - I understand if I cancel or No-Show a scheduled appointment, refills will not be sent till I am seen again in-person or by telehealth (when applicable).
    - I will **not** request early refills on medications. (If you plan to go out of town, please plan accordingly to ensure you have enough to travel).
    - Lost, stolen, or misplaced medications may **not** be replaced. I'm aware a Police report may be required as well.
    - I understand that failure to attend follow-up appointments with my doctor or nurse practitioner may result in discontinuation of medication.
    - I understand that my doctor or nurse practitioner has the right to adjust, change, or stop my medication during any encounter.
4. **Monitoring and Compliance**
    - I understand routine vitals may be taken or requested of me at every in-person or telehealth appointment. My provider may require me to come in-person between visits before refills are provided if deemed necessary.
    - I agree to periodic **urine drug screens**, **blood lab work**, **pill counts**, and **review of prescription monitoring programs** (e.g., PMP, PDMP).
    - I understand that non-compliance, including a positive drug screen for illicit drugs or unprescribed medications may result in tapering, discontinuation of medication, or referral to specialized care.

Acknowledgment and Consent

I acknowledge that failing to disclose relevant medical information may put my health at risk and interfere with safe medication management. I understand that if I do not report medical issues, this may result in the discontinuation of controlled substances and or discharge from psychiatric care at this practice.

I have read this agreement (or had it read to me). I understand the information and agree to the terms.

Patient/Guardian Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____
Provider Name: _____