Controlled Medication Agreement

The following agreement is intended to assist the patient in understanding and complying with the laws concerning controlled pharmaceuticals. By signing this agreement, I agree to the following:

- I confirm that I will NOT use any illegal substances during the course of this agreement.
- I confirm that I will NOT share my medications with anyone else.
- I confirm that I will NOT attempt to acquire controlled medications from another provide OR by illegal means.
- If prescribed by my physician, I agree to receive scheduled (i.e., controlled) medications. I understand that these medications are being prescribed to improve my functioning.
- I understand that there is a known risk of psychological and/or physical dependence associated with the chronic use of controlled medications.
- I will seek out psychiatric treatment, psychotherapy, or other forms of treatment if my provider deems it necessary.
- I agree to undergo blood and/or urine tests if requested by my provider.
- I authorize cooperation between my provider and pharmacy with any law enforcement agency during any investigation of possible misuse, sale, or other illegal diversion of my medications.
- I will communicate openly and comprehensively any benefits and/or side effects of my medications.
- I will safeguard my medication from loss, theft, or use (both intentional and unintentional) by others. I will file a police report should my medication be stolen, and understand that in the case of theft or loss, my medication may not be replaced.
- I understand that my provider may use the Prescription Monitoring Program to confirm that I only receive medications from one provider.
- I agree to take my medications as prescribed. I understand that taking my medications at a faster rate than prescribed will result in being without medication for a period of time.
- I understand that if I breach this agreement, my provide may halt prescription of my controlled medications. This may include tapering my medications to avoid a withdrawal or referral to a treatment facility.

Signature: _____ Date: _____