CONTROLLED SUBSTANCES FORM

Controlled medications (i.e., benzodiazepines, stimulants, hypnotic sleep aids) have a high potential for misuse and are, therefore, closely regulated by local, state, and federal governments. Our clinicians must observe strict rules in order to minimize the risks of abuse and misuse. All patients at Specialty Clinic of Austin (SCOA) must agree to follow the policies outlined in this agreement as a condition of the provision of controlled substance medications by my clinician.

Please initial next to each statement to indicate your understaning and agreement.:

_____ I understand that consumption of controlled substances is associated with risks including, but not limited to, psychological addiction, physical dependence, withdrawal, and overdose.

_____ I agree to utilize the prescribed medication as instructed. Changing the way I take my medication (i.e., taking my medication more than as directed or abruptly stopping my medication) is prohibited and can result in adverse health outcomes.

- I will not alter the date, quantity, and/or strength of my prescribed medications. I will not break, chew, crush, inject, or snort my medications.
- I will not alter a prescription by any means, shape, or form. Forging prescriptions and/or my clinician's signature violates state and federal law.
- I agree to keep my prescription(s) in a secure and safe location and to safeguard my prescription(s) against loss or theft. I will not sell my medication or share it with others, or in any other manner enable other individuals to possess or use my prescribed medications.

_____ **I understand that absolutely no premature refills will be granted regardless of the circumstances (i.e., stolen, misplaced, mislaid, exceeding prescribed dosages, losing a handwritten prescription prior to filling, etc.).** I must wait until the next eligible fill date to receive another prescription.

- **I may be discharged from the clinic if I request an early refill secondary to lost, damaged, or stolen prescriptions twice within one year.**

_____ I understand that my clinician follows state and federal recommendations regarding the use of urine toxicology screens to monitor controlled substances use. **I agree to cooperate with urine toxicology screenings, which will be ordered by my clinician prior to prescribing a controlled substance and randomly during the course of my treatment.**

- **Any charges associated with the toxicology screen will be my responsibility if they are not covered by my insurance carrier.**
- Refusal to consent to toxicology screens, the presence of nonprescribed or illicit substances in my sample, or the absence of prescribed medications in my sample will result in discontinuation of controlled substances and may result in termination of care.
- In the event of inconsistent results, my clinician may contact me to present to the office for a follow-up test; if I fail to present within 24 hours of receiving this phone call my controlled substance prescriptions will be terminated. **I must keep my contact information current so my clinician may reach me, as any missed tests will be considered to be a violation of this agreement.**

Expert Care

CONTROLLED SUBSTANCES FORM (Cont'd)

Please initial next to each statement to indicate your understaning and agreement.:

_____ I will obtain all medications for the treatment of my psychiatric condition solely from SCOA unless previous clearance has been obtained by my SCOA clinician. I will not obtain controlled substance prescriptions from multiple providers. If I receive other controlled substance prescriptions from any source other than my SCOA clinician, without notifying my SCOA clinician, I will be discharged from the clinic.

- I understand and consent that my clinician can and will utilize the following resources to obtain a history of my prescribed medications: requesting information from my past/current treating physician, requesting information from my current or previous pharmacy, and conducting a Department of Public Safety (DPS) report through the State of Texas several times per year (Texas Prescription Drug Monitoring Database). My DPS reports will become part of my medical record.
- I will communicate with other providers who are treating me that I am under a controlled substance agreement with SCOA. I consent to release this agreement information to other providers, emergency departments, pharmacies, and consultants to allow pharmacies to release my prescription history. I also consent for other providers, emergency departments, pharmacies, and consultants to report violations of this agreement to SCOA and my primary care provider.

_____ I understand that changes in any controlled substance prescription will only be made in the context of a clinic visit and never via telephone and/or during non-clinic hours.

- Refills are exclusively provided as determined by my clinician, will only be granted if I keep my scheduled appointments, and will not be granted outside of regular business hours.

_____ I agree to inform my clinician of any new medications or medical conditions that arise during the course of my treatment. I will notify my clinician of any adverse effects I experience from any of the medications I consume.

_____ I will inform my clinician of any current or past substance abuse. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

- I agree not to use alcohol or any illegal substances (including, but not limited to, marijuana, heroin, cocaine, and amphetamines) while under this agreement.
- I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances which impairs my driving ability, may result in DUI charges and/or other legal charges.

_____ I understand that if I violate any of the above policies, all orders for my controlled substance prescriptions will cease and I will be dismissed from the clinic.

- I understand that my clinician fully cooperates with local, state, and federal law enforcement agencies as well as the Drug Enforcement Agency (DEA) and the Department of Public Safety (DPS) in regards to infractions involving prescription medications. My pharmacy, local authorities, and the DEA will be notified if my treating clinician believes that I have violated the laws regarding controlled substance prescriptions in any manner.
- If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtain medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substance administration.

Expert Care

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCES AGREEMENT

I have read and understand the policies regarding controlled substance prescriptions. I voluntarily agree to the terms involved in the Controlled Substances Form. I understand that if any of the above policies are violated or I choose not to adhere to these policies, I will be dismissed from this clinic and will not receive any refills from the treating clinician.

☐ I agree that my electronic signature on this application is binding and enforceable, as if I had signed a paper copy.

Patient Name: _____ Date: _____

Patient Signature (or Legal Guardian, if a minor): _____