***SUMMERVILLE PSYCHIATRIC ASSOCIATES***

## CONTROLLED SUBSTANCE MEDICATION AGREEMENT (SCHEDULE II-V)

Controlled substance medications are closely controlled by local, state, and federal governments. Due to the high potential for misuse/abuse, strict accountability is necessary. Prescribers are required to check the national database for other sources of prescriptions on a regular basis.

In order for your provider to consider prescribing or continue to prescribe controlled substances to you, there must be an agreement to the following terms:

**I, the undersigned, agree to the following;**

1. I am responsible for controlled substance medication paper prescriptions and controlled substance medications prescribed to me. I am required to inform the prescriber of these medications of ALL controlled substance medications that have been prescribed for me by other providers. This includes other physicians, urgent care centers, emergency rooms, or hospitals. If my prescription is lost, misplaced, stolen, or if I "run out early," I understand that it will not be replaced. I will take my medication strictly as prescribed and will not take additional doses without approval from my prescriber. If I run out of medication due to taking more than prescribed, I understand that it will not be replaced. I understand that misuse could result in serious medical complications, including death.

    a. Refills of controlled substance medication:

        i. Will NOT be provided after hours (i.e., evenings, weekends, or holidays)

        ii. Will NOT be provided if I run out early, lose a paper prescription, spill or misplace my medication, or if I have my prescription or medication stolen. I am responsible for taking the medication in the prescribed dose and keeping track of the remaining amount.

        iii. Will NOT be provided as an "emergency." I will call at least 1 week in advance if I need a refill.

        iv. Will only be provided by my prescriber at their discretion.

2. I will establish an ongoing relationship with ONE pharmacy and get my controlled substance medications refilled only at that pharmacy. I understand that in the context of monitoring my medications, my prescriber may communicate with my pharmacist and DHEC's Prescription Drug Monitoring program for the purpose of monitoring prescriptions. Should the need arise to change pharmacies, I will notify the office.

3. I agree to comply with random urine, saliva, and/or blood testing and/or pill counts documenting proper use of my medications as well as confirming compliance and absence of use of alcohol and other drugs including illicit (illegal) substances. I agree that I am ultimately responsible for the costs associated with such testing if my insurance does not cover such testing.

4. I understand that driving a motor vehicle may not be allowed while taking certain controlled substance medications and that it is my responsibility to comply with the state laws in which I am taking the prescribed medications.

5. I agree not to share, sell, or trade my prescribed medications. I will also safeguard my medication from theft, loss, or potential misuse (i.e., leaving my medication where others can access them, particularly children).

6. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual or provider, or the concomitant use of non-prescribed illicit (illegal) drugs, it may also be reported to my physicians, medical facilities, and the appropriate authorities.

7. I understand that the medications prescribed have the potential to be habit-forming or lead to psychological or physical dependence (addiction). If I decide to stop using my medication I will do so under the medical supervision of my prescriber.

8. I understand that verbal or physical abuse directed to my prescriber and their staff will not be tolerated and may result in immediate discharge from the practice.

9. For female patients, if you plan on becoming pregnant, are pregnant, become pregnant, or are breastfeeding, you MUST notify all of your healthcare providers. Controlled substances may harm your baby or your ability to become pregnant.

10. I agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance medication prescribing by this provider or referral for further specialty assessment (i.e., pain management, neurological assessments, etc.).

11. I agree that prescription renewals are contingent on keeping scheduled appointments. Under the discretion of my prescriber, I will be required to schedule appointments for refills approximately every 3 months. If I receive any controlled substances in an ER or Urgent Care center, I must report that incident to my prescriber within 48 hours.

12. I recognize that any medical treatment is a trial and that continued prescribing of a controlled substance medication is contingent on evidence of benefit and improved functionality.

13. I understand that if I violate any of the above conditions, my treatment with controlled substance medications may be terminated immediately, without a 30-day notice.

14. I understand that I am responsible for any withdrawal syndrome that may occur due to my misuse of any prescribed medications and/or termination of my care.

**BY SIGNING BELOW I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS AGREEMENT AND UNDERSTAND THE CONSEQUENCES OF VIOLATING THE TERMS OF THIS AGREEMENT, WHICH INCLUDE POTENTIAL DISCONTINUATION OF PRESCRIPTION CONTROLLED SUBSTANCE MEDICATIONS WRITTEN BY MY PRESCRIBER AND POSSIBLE TERMINATION OF THE PHYSICIAN/PATIENT RELATIONSHIP.**

**Name (Print):** ______________________________________________________________

**Signature:** ___________________________________________ **Date:** ________________

**Patient Name (if different from above):** __________________________________________