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Controlled Substances Treatment Agreement

I understand that compliance with the following guidelines is important for continuing treatment with Sugi Psychiatry. I understand that I have the following responsibilities and agree to adhere to the following rules while I am under the care of Sugi Psychiatry and Wellness.

PLEASE INITIAL NEXT TO EACH NUMBER.

_____ 1. I will take the medication as prescribed.

_____ 2. I will not increase or decrease dose and/ or frequency of medications taken without approval of my physician/ APP.

_____ 3. I will not obtain controlled medications from providers outside of Sugi Psychiatry. In a case when I have this medication prescribed by a different provider (for example in emergency department or with primary care) Sugi Psychiatry must be notified immediately.

_____ 4. I will not share this medication with anyone, including family members, even if they also are prescribed this medication.

_____ 5. I will not sell this medication.

_____ 6. I will not get replacement for any lost or stolen medication regardless of circumstance.

_____ 7. I will not get early refills.

IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOUR PHARMACY HAS YOUR MEDICATION IN STOCK, PRIOR TO THE PRESCRIPTION BEING SENT. ONCE IT HAS BEEN SENT, IT CANNOT BE CHANGED. WE CANNOT CALL PHARMACIES FOR YOU TO CONFIRM IF THE MEDICATION IS IN STOCK.

_____ 8. I will ensure that, before the initial prescription or refill is sent to pharmacy, the pharmacy has the correct medication in stock. Sugi Psychiatry is not responsible for confirming the inventory at pharmacies.

8a. Once a prescription has been sent to a pharmacy, Sugi Psychiatry cannot send the prescription to a different pharmacy within a 30-day period.

8b. Once your prescription has been sent to the pharmacy, the dose, type or kind of prescription cannot be changed within a 30-day period without an appointment.

_____ 9. I will notify my provider if I use alcohol or use other illicit drugs while using this medication. [For benzodiazepine prescriptions, no alcohol may be consumed, nor any other sedating medications including prescription opioids]. Continual use of illicit substances while being prescribed a controlled substance may result in discontinuation of the prescription or dismissal from the practice.

_____ 10. I agree to monthly urine drug screening and breathalyzer tests. If I was assigned female at birth, and I am between 10-50 yrs old, I also agree to a monthly pregnancy test.

_____ 11. I agree to periodic random pill counts.

_____ 12. I agree to participate in adjunctive management programs such as: psychological testing, counseling therapy, behavioral modification, school-based interventions, twelve-step programs, and/or job modification if recommended by the physician/APP.

_____ 13. I will not request prescription refills when the clinic is closed, after hours or on weekends.

_____ 14. I will store my medications in a secure location at all times to reduce the risk of loss or theft. If I have medication remaining that I no longer need, I will securely dispose of it.

_____ 15. I understand that I must attend monthly in-person appointments with my physician/APP to maintain compliance with clinic policy. I understand that cancellations/no shows may result in delays or discontinuation of the prescription.

_____ 16. If I am pregnant or intend to get pregnant, I am required to notify Sugi Psychiatry immediately to discuss tapering off medication that could potentially harm the fetus. I understand that failure to do so may result in dismissal from the practice. I will not hold the clinic responsible for any harm that may occur to me and/ or my unborn child.

_____ 17. I consent to share information with other health care professionals if my physician/APP determines it is medically necessary. My pharmacy may be receiving a copy of this treatment agreement.

_____ 18. I will discuss with my physician/APP prior to stopping this medication, as there may be serious side effects or withdrawal symptoms when abruptly stopped.

I UNDERSTAND THAT MY PHYSICIAN/APP MAY STOP PRESCRIBING THE MEDICATION OR CHANGE THE TREATMENT PLAN IF I FAIL TO FOLLOW THE ABOVE RECOMMENDATIONS.

_____	_____
Patient Name	*Patient Date of Birth*
_____	_____
Signature	*Date*
_____	_____
Responsible Party Name (If other than Patient)	*Relationship to Patient*