Ivy Collaborative Healthcare

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Controlled Substance Agreement

The safety and care of our patients is our number one priority! This policy was designed with your care and safety in mind. State laws define controlled substances as not just narcotics, but also medications for ADHD, sleep, weight loss and anxiety. Patients who are prescribed any of the above medications (or their guardians) are asked to sign this controlled substance agreement which outlines our policy. We ask our patients and their families to understand that this policy is in the best interest of our patients.

1. I will take the medication(s) exactly as directed and I will not increase, decrease and/or change the frequency the medication is taken without prior approval of my physician/APRN.
2. I will report any suspected side effects to my physician/APRN immediately.
3. I agree to inform my physician/APRN of ALL medications I am taking including herbal remedies, since controlled substances can interact with over the counter-the-counter medications and other prescribed medications (eg. cough syrup that contains alcohol, hydrocodone, codeine, etc.)
4. I understand that this medication(s) is for my personal use only. I will not share the medication with anyone including family members. I understand that it is illegal for me to use medications that are not prescribed to me.
5. If I use up my medication sooner than prescribed, I understand Ivy Collaborative Healthcare will not refill my medication until it is time for the scheduled refill.
6. I understand that I am responsible for keeping track of the amount of medication and will plan ahead of time so that I will not run out of medication. I understand that the above type of medication(s) will only be refilled during regular business hours. Your physician/APRN will not refill these types of medications after hours, on weekends or holidays. I understand that I will call at least five (5) days before my medication(s) run out.
7. I recognize that my psychiatrist/APRN is not obligated, nor will she/he automatically refill prescriptions for controlled medications that I have been receiving from another physician/APRN.
8. If my medication needs to be changed to another medication, I understand that I may be asked to return the remaining portion of the previous prescription for disposal.
9. If a medication is lost, stolen or misplaced, the prescription will not be replaced. Proof of a police report will need to be provided should a theft occur.
10. If required, I agree to bring my medication bottle(s) to the office for the purpose of a pill count.
11. I agree to participate in adjunctive management programs such as: psychological testing, talk/counseling therapy, behavioral modification, job modifications, school-based interventions if recommended by my physician/APRN.
12. I understand that it is my responsibility protect and secure my medications. This includes but is not limited to keeping medications our of the reach of children and pets.
13. I agree and understand that my physician/APRN reserves the right to obtain random or unannounced prescription drug testing, including urine, blood, saliva or and/or hair testing. If I fail to provide the sample when asked or if the results are inconsistent, I may forfeit the right to continue receiving care.
14. I understand that altering a prescription in any way is unlawful. Fabricating prescriptions or forging a provider's signature is also against the law.
15. For Women: If I am pregnant or intend to become pregnant, I am required to notify Ivy Collaborative Healthcare immediately to discuss tapering off medication(s) that could potentially harm the baby. I understand that my failure to do so may result in discharge from the practice. I will not hold Ivy Collaborative Healthcare responsible for any harm that may occur to my and/or my unborn.

My signature below indicates that I have read this document and understand it. I have had all of my questions answered to my satisfaction. I agree to honor this policy above and I understand that failure to abide by this agreement will result in my termination of controlled medication prescriptions and possibly termination of services from Ivy Collaborative Healthcare.

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

Print name:_____