LUBBOCK PSYCHIATRY, PLLC
CANE RIVER PROVIDERS, PLLC
SUNLIGHT PEAK PSYCHIATRY, LLC

Patient's Name: _____

Patient's Date of Birth (DOB): _____

Controlled Substance Agreement

We are committed to doing all we can to treat your mental health condition. In some cases, controlled substances are used as a therapeutic option in the management of mental illness, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our," refer to the facility and/or prescribing physician(s), and the words "I," "you," "me," or "my," refer to you the patient.

1. All controlled substances must come from the physician who signature appears below or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications, or supplements. Failure to do so may result in drug interactions or overdose that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, health-care provider, or dentist. I understand it is unlawful to be prescribed the same controlled substance by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substance that I have been prescribed).

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ Phone: _____

3. You may not share, sell, or otherwise permit others, including spouse or family members; to have access to any controlled substances that you may have been prescribed.

4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1, above. I will not use, or purchase or otherwise obtain any illegal drugs/substances. I understand that driving and/or operating heavy machinery while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges, and poses a danger to myself and others.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, discarded, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescription after hours or weekends.

8. In the event you are arrested or incarcerated related to legal or illegal drug (including alcohol), refills on controlled substances will not be given.

9. I understand that as required by Texas Administrative Code, Title 22, Part 9, Chapter 170, Rule 170, Subchapter C, Rule §170.9; that before a prescription or refill of a controlled substance, a mandatory Prescription Monitoring Program (PMP) check of the patient's controlled substance prescription history is required, and will be performed.

10. I understand that failure to adhere to the policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at this facility and that law enforcement officials may be contacted.

11. I affirmed that I have full right, capacity, and power to sign and be bound by this agreement, and that I have read, understood, and accept all of its terms. A copy of this document has been given to me.

12. I will not take more medication than prescribed, unless directed to do so by my physician.

13. I will be discharged from this psychiatry clinic if I break any of these rules. No exceptions.

_____ _____

Print Patient Full Name | Print Guardian/Legal Representative's Full Name

_____ _____

Patient's Signature | Guardian/Legal Representative's Signature

_____ _____

Date | Date

_____

Print Physician's Full Name

_____

Physician's Signature

_____

Date