River Valley Behavioral Health & Wellness Center

Agreement for Safe & Effective Controlled Substance Prescription

The Agreement is between _____Date of Birth _____ and River Valley Behavioral Health & Wellness Center. My psychiatric provider has prescribed one or more medications to treat my condition: _____. These medications are high risk and can be misused, abused, or lead to addiction. In order to comply with federal and state regulation and for my safety, I agree to the following statements. **I know that if I do not follow the statements below, my controlled substance prescription and/or treatment at River Valley Behavioral Health & Wellness Center may be ended immediately.**

1. I know that controlled substances are one part of my treatment plan to help my condition and make my quality of life better. I know that controlled substances will not cure my condition and my provider may recommend other treatment modalities to help my condition. I understand that if my function does not improve while on these medications, the medicine may be discontinued or the dose adjusted.
2. I know that my treatment may change as my provider evaluates my progress or more medical information is available. If my provider feels I need to see a specialist, my provider will provide me with referral information.
3. I know that if I stop the medication suddenly, I may have withdrawal symptoms.
4. I am responsible for my controlled substance medications and agree to store them in a secure location which is not accessible to anyone other than myself. I understand that sharing, selling, or trading my medication is illegal and is a felony. If the paper prescription and/or the medication is lost, misplaced, or stolen, or if I use it up too soon, I know that the medication will not be replaced as required by legal mandates. I agree to bring in my medications for pill counts at the request of my provider.
5. I will not ask for or take controlled substance medications from another doctor or person. If I am given these medications by another health care provider or in a time of emergency, I understand I will inform River Valley Behavioral Health & Wellness Center the next business day to let my provider know.
6. Refills of controlled substances will only be provided if I keep my scheduled appointment(s). I will call at least 3 business days ahead if I need a refill on the controlled substance medications and I know that refills will only be granted during my provider's regular business hours.
7. I know that any controlled substance may interfere with or impair my ability to drive, perform intricate tasks and make important decisions. I understand that it is my responsibility to refrain from any activities that will endanger me or others while taking a controlled substance.
8. I understand the use of illegal drugs will negatively impact my response to treatment. I also understand that if my provider suspects drug use that could compromise my health, my medications will be discontinued, my provider may order a drug test, and/or my provider will refer me to chemical dependency treatment.
9. I agree to use **_____ pharmacy, located at _____** for **ALL** my controlled substances. If I change my pharmacy for any reason, I agree to tell my provider.
10. ___ **For females of child bearing potential**, I understand that taking controlled substances while pregnant is dangerous. Taking controlled substances during pregnancy can cause harm to a fetus and can lead to severe neonatal withdrawal after birth.

I have read and I understand this agreement. A signed copy will be placed in my file.

Client's Signature _____ **Date** _____

Psychiatric Provider or RN Signature _____ Date _____