Farrah Thornsberry:
Psychiatric & Mental Health Services
2815 Taylorsville Road Lane, Suite 101
Louisville, KY 40205
(502)618-3344 - Fax

CONTROLLED SUBSTANCE AGREEMENT

I, _____, a patient/guardian of a patient at this practice, have been informed that prescribed controlled substances including, but not limited to stimulants, benzodiazepines, controlled sleep aids, or sedatives have the potential risk of abuse and require close monitoring.

I have been informed it is necessary to observe strict rules pertaining to their use and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the prescriber whose signature appears below to consider prescribing or to continue prescribing controlled substances as part of my treatment regimen.

1. I will inform my prescribing provider of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family.
2. I agree that I may be subject to a voluntary evaluation by another professional if required.
3. I understand the need to be re-evaluated frequently by my prescriber for the continuation of the medication.
4. I will inform my prescriber at this practice of any new medications, supplements, vitamins, substances or medical conditions, as well as any adverse effects I experience from the medications I am prescribed.
5. I understand my prescriber cannot by law prescribe more than a 30-day supply of a controlled substance. If the medication is lost, damaged or stolen, my medication will not be filled early
6. I will inform my provider of any other controlled substances I am prescribed by other providers and agree that only controlled substances pertaining to your mental health diagnosis will be prescribed at this practice.
7. I will inform my other health care providers of any controlled substances I am prescribed at this practice. This includes emergency room prescribing providers.
8. I agree that my prescribing provider has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my prescription for controlled substances for the purposes of maintaining accountability.
9. I will not allow anyone else to have, use, or otherwise have access to these medications and understand the sharing of these medications is against the law and can result in legal issues.
10. I understand that for the safety of others, these medications must be kept out of reach and stored in a secured location. I understand that individuals who are not prescribed these medications and have not been evaluated for their use could be in danger if he/she took the medication.
11. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.
12. I agree I will take my medication, as prescribed by the provider and will not alter or attempt to administer in a way other than prescribed.
13. I understand that dosage changes must be approved by my provider.
14. I understand that I should discuss with my provider before abruptly stopping the medication and discuss a tapering plan if needed.
15. I understand that at any point, the prescriber can request that a random toxicology screening be completed and failure to do so may result in delay or denial of refill request.
16. I understand that any medical treatment is initially a trial, with the goal of treatment being to minimize symptoms and improve the quality of life and my ability to function and/or work. These parameters will be assessed periodically to determine benefits of medication continuation.

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17. I understand that medication refills will occur Monday – Friday 9:00 am until 5:30 pm (excluding holidays) Eastern Standard time. If I contact the provider outside of regular business days/hours, I understand that a response will not occur until the next business day.
18. I have been explained the risks, potential benefits, side effects, and alternatives.
19. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this provider, as well as potential termination of treatment.
20. I, the undersigned patient/guardian, attest that I have read, understand and agree to all of the above requirements.

_____	_____
Provider Signature	Patient/Guardian Signature
_____	_____
Provider Name (Print)	Patient/Guardian Name (Print)
_____	_____
Date	Date