Avenues Unlimited

THERAPY | EDUCATION | WORKSHOPS

Controlled Substance Contract

** I understand that if I have ANY discrepancies in my Drug Screening my controlled substance will NOT be prescribed. **

1) I am responsible for **MY** controlled substance medication. If the prescription or medication is lost, misplaced, stolen or if I use it up sooner than prescribed, I understand that it will NOT be replaced. I am aware that I must report Stolen medications to the police.

2) I will not request nor accept the controlled substance (prescribed by this office) from any other physician or individual while I am receiving such medication from my provider at Avenues Unlimited. Besides being illegal to do so, this may endanger my health. The ONLY exception is if it is if it is prescribed while I am admitted in a hospital or discussed with my provider PRIOR.

3) I understand that although a medication may be prescribed in a hospital or by another physician, it is up to the discretion of my individual provider at Avenues Unlimited as to whether they are willing to prescribe a medication.

4) **REFILLS OF CONTROLLED SUBSTANCES:**
   A. **A SINGLE PHARMACY WILL BE USED**: I will notify Avenues Unlimited if I am going to change pharmacies, PRIOR to filling my prescription, using multiple pharmacies will not be allowed.
   B. Refill request **MUST** be made during regular office hours via electronic request from your pharmacy.
   C. Refill requests are **YOUR** responsibility and **MUST be made at least 5 to 7 business days** prior to needing a new prescription.
   D. ALL refills will be sent electronically.
   E. Refills will NOT be authorized by your provider at night, on holidays or weekends.

***** **Avenues Unlimited will not authorize early refills. I understand that if I run out early, I may experience withdrawal symptoms. I will not take more medication than prescribed, unless advised by my provider. Some controlled substances can cause severe withdrawal enough to require medical intervention and I have been educated on those substances.** *****

5) *** Completion of an Initial Drug Screen (for all new patients 16 y/o and older) and follow up random drug screenings **is a requirement to receive** controlled substances.

** I understand that my provider reserves the right to complete a random drug screen at any time if deemed necessary.

6) I understand that if I violate ANY of the above conditions, my controlled substance prescription and or treatment will be ended immediately. If the violation involves obtaining a controlled substance from another physician or individual, as described above, the violation may also be reported to your primary care physician, local medical facilities and other authorities.

7) I will not take any illegal drugs. I understand that taking any non-prescribed may be grounds for termination.

8) I understand that the main treatment goal is to improve my ability to function and / or work. In consideration of that goal, and that I am being given a potent medication to reach my goal, I agree to help myself by following better health habits, specifically involving exercise, weight control and exercising moderation in alcohol and tobacco products. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to treatment.

9) I understand that if my provider feels that I am not taking my medications in the prescribed manor, or the medications are NOT improving my ability to function then I will be weaned off the medications prescribed.

10) I have been fully informed about the psychological dependency (addiction) of controlled substances, which I understand is possible. I understand that some persons may develop tolerance, (which means an increase in the dose of the medication may needed to achieve the same effect of symptom control) and I do know that I will become physically dependent on the medication, this will occur if I am on the medication for several weeks and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

Signature: _____ Date/Time: _____

Print Name: _____ Date/Time: _____