Client Name: _____

Date Effective: _____ Review Date: _____

Client Agreement for Controlled Substances

The purpose of this agreement is to give you information about the medications you will be taking at this practice, and to ensure that you and Heart & Soul Community Counseling, Inc. comply with all the New York and Federal Regulations concerning the prescribing of controlled substances.

The success of treatment depends on mutual trust and honesty in the client-prescriber relationship and full agreement and understanding of the risks and benefits of using potentially addictive drugs.

In signing this agreement, you have agreed to use of potentially addictive medications as part of your treatment. These controlled substances can be very useful, but have a high potential for misuse and are therefore closely controlled by state and federal governments. Because your prescriber is recommending such medication to help manage your condition, it is considered good practice to agree to the conditions outlined below.

My responsibilities of a client include:

- I agree to see one prescriber at one practice for all my psychiatric medications
- I will have all my medications dispensed at one pharmacy
- I will inform my prescriber of all medications I am taking, including over the counter medications and illicit substances. Medications can interact with drugs of dependence and can produce serious side effects.
- I will communicate fully with my prescriber to the best of my ability at the initial appointment and all follow-up visits my symptoms along with any side effects of the medications. This information allows my prescriber to adjust my treatment plan accordingly.
- I understand the use of alcohol together with controlled substances is contraindicated.
- I will not use any illicit substances (i.e. cocaine, marijuana, and heroin), while taking these medications. Use of these substances may result in a change in my treatment plan, including safe discontinuation of my medications or complete termination of the client-prescriber relationship.
- If I have a history of alcohol or drug misuse/addiction, I must notify my prescriber of such history since treatment with controlled substances may increase the possibility of relapse.

- I agree and understand that my prescriber reserves the right to perform random or unannounced drug testing. If requested to take a drug test, I agree to comply. If I decide not to provide a sample, I understand that my prescriber may change my treatment plan, including safe discontinuation of my medications when applicable or complete termination of the client-prescriber relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the client-prescribed relationship. Drug testing is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances
- I agree to allow my prescriber to contact any healthcare professional (i.e. therapist, primary care physician), pharmacy, or other legal authority to obtain or provide information about my care or actions, if my prescriber feels it is necessary.
- I understand my capacity to drive may be affected and I may be asked to cease driving.
- I accept that set appointments must be made to review ongoing therapy. This should be monthly and made at the last appointment. No walk-in appointments for medication refills will be granted.
- If an appointment is missed, another appointment will be made once all fees have been paid. Immediate or emergency appointments may not be able to be accommodated.

My Prescriptions

- I am responsible for my prescriptions. I understand that lost prescriptions may not be replaced.
- I understand that prescriptions will not be mailed if I am unable to obtain my prescriptions monthly.
- Repeat prescriptions can be written for a maximum of 1 month supply and will be filled at the same pharmacy.
- Pharmacy: _____ Phone Number: _____
- It is my responsibility to schedule appointments for the next prescription before I leave my appointment.

Taking My Medications

- I understand that the medication is strictly for my own use. My medication should never be given or sold to others because it may endanger that person's health and is against the law.
- I am responsible for keeping my medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my doctor. If my medications are lost, misplaced or stolen my prescriber may choose not to replace the medications or to taper and discontinue the medications.
- I am responsible for taking my medications as directed. I agree to take the medication only as prescribed.
- I understand that increasing my dose without the close supervision of my doctor could lead to a drug overdose, causing severe sedation, respiratory depression and death.
- I understand that decreasing or stopping my medication without close supervision of my doctor can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
- Any evidence of drug hoarding, acquisition of any opioid medication or additional analgesia from other doctors (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the client-prescriber relationship.

I understand that non-compliance with the above conditions may result in a reevaluation of my treatment plan or discontinuation of my treatment. I may be gradually taken off these medications, or even discharged from Heart & Soul Community Counseling, Inc.

I, _____, have read the above information or it has been read to me and all my questions regarding my treatment plan using controlled substances have been answered to my satisfaction. I hereby give my consent to participate in this medication therapy and acknowledge receipt of this document.

Client Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____