Living Well Behavioral Health, Inc.

Controlled Substance Medication Agreement

I, _____, understand and voluntarily agree that (initial each statement after reviewing):

_____ I will keep the medicine safe, secure and out of the reach of children and others. If the medicine is lost or stolen, I understand it WILL NOT be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the medical staff.

_____ I WILL NOT CALL BETWEEN APPOINTMENTS, OR AT NIGHT OR ON THE WEEKENDS LOOKING FOR REFILLS. I UNDERSTAND THAT PRESCRIPTIONS WILL BE FILLED ONLY DURING SCHEDULED OFFICE VISITS WITH MY PROVIDER.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the staff immediately. I understand that I may not receive medications at that time.

_____ I will treat the staff at Living Well respectfully at all times.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to allow the doctor to speak to all other doctors or providers that I see, about controlled medications, and any treatment I receive.

_____ I will inform the doctor of all medications I am currently taking, and let him/her know immediately if I receive a prescription for a new medication. I am to report any narcotic pain medication I receive from another doctor by the next business day.

_____ I will use only one pharmacy to obtain all of my medications: _____

_____ I will not receive any other benzodiazepines (klonopin, Xanax, valium) or stimulants (ritalin, amphetamine) from any other doctor.

_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____ I will take a drug test and any lab work requested by my provider.

_____ I will keep up to date with any bills from the office and tell the doctor or staff if I lose my insurance or can no longer pay for treatment.

_____ I will not alter or write on the prescription at any time. This is considered Forgery and is punishable by law.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Our agreement to you:

We at Living Well Behavioral Health, Inc. are committed to working with you in your efforts to improve your health. To assist you with this, we agree that:

We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointment for any reason, we will ensure you have enough medication to last until your next appointment.

We will ensure that this treatment is as safe as possible. We will check regularly to ensure you are not having any negative side effects to the medication(s).

We will help complete any paperwork necessary for insurance purposes, allowing you to fill your prescription(s).

Patient Signature: _____ Date: _____

Patient Name (Printed): _____

Provider Signature: _____ Date: _____

Provider Name (Printed): _____