Contracts

Client Name: **Staff Name:**

Client ID: **Date of Contract:**

CONTROLLED MEDICATION CONTRACT

I understand that I have been prescribed a medication that is a controlled substance, which means that there are special regulations in prescribing and dispensing them. I also understand that in the state of West Virginia it is illegal to go from doctor to doctor to obtain these types of medications.

Controlled substances are medications from the Benzodiazepine class, which includes Xanax (alprazolam), Ativan (Lorazepam), Valium (Diazepam), Librium (Chlordiazepoxide), Klonopin (Clonazepam), Serax (Oxazepam), Restoril (temazepam), the stimulant class, which includes Ritalin, Metadate, Focalin, Concerta (methylphenidate) and Adderall or Vyvanse (amphetamine) or sleep agents like Ambien (Zolpidem), Lunesta (eszopiclone) or Sonata (Zaleplon). Neurontin (Gabapentin), a medication used off label for mood stabilization, is also considered a controlled substance.

I understand that it is my responsibility to store my medications in a safe place, and to avoid misplacing, losing or having my medication stolen. No early refills will be authorized for any reason.

I agree not to take more medication than is prescribed and not to sell or share my medications. I will inform my physician of any other medications I am prescribed by other physicians, especially medication for sleep, nervousness or pain. No prescriptions will be issued for benzodiazepines when it is determined that the consumer has been prescribed opiates.

I understand that Benzodiazepines, stimulants and some sleep agents are potentially **addictive (habit forming)** substances. When taken long-term (more than a few weeks), people can develop physical dependence. Symptoms of physical dependence are tolerance (need to increase the dose in order to obtain the same effect) and withdrawal upon abrupt discontinuation that can be life threatening, including seizures and death.

I agree never to drink alcohol or use any illicit drugs while taking this medication. I understand that the interaction can be extremely dangerous, even lethal.

I understand that I may be required to provide urine for urine screens and I may be called to come to the clinic for pill counts.

I agree to keep my provider updated of my contact information (working phone number).

Contracts

Client Name: **Staff Name:**

Client ID: **Date of Contract:**

I understand if my provider becomes aware of any abuse or misuse of prescribed medication or if I fail to comply with conditions of this agreement, no further prescriptions will be issued and I will be referred for substance abuse treatment.

____ __________________________

Patient Signature Date

Electronically signed by ______________________________ on ________________ at __________
Credentials _________.

Revised 5/27/20