Plymouth Psych Group

PSYCHIATRIC CONTROLLED SUBSTANCE MANAGEMENT AGREEMENT

Name: (Last, First, M.I.)	**Date of Birth:**

This form acknowledges that the use of a Controlled Substance medication for my psychiatric care was a decision made between my provider and myself because of my specific condition. By signing this form, I acknowledge, understand and agree to the following conditions to make my treatment as safe and successful as possible.

Please initial:

_____ I am aware that use of this medication has certain risks associated with it including habituation and dependence. I have reviewed the risks and benefits information with my provider.

_____ I agree to help myself by actively participating in psychotherapy to reach my treatment plan goals, maintaining as healthy a lifestyle as possible, refraining from illicit drug use, and remaining compliant with medication treatment plan.

_____ I agree to notify my provider of any changes, emergency room visits, and/or acute psychiatric service visits, lost or stolen medication, or any other circumstances affecting my health and well-being.

_____ I agree to receive the prescribed controlled substance only from my psychiatric provider. I will not seek this medication from any other provider, friend, relative, or non-prescriber while I am under psychiatric care at Plymouth Psych Group, except during the case of hospital admission medication changes. I am aware that my provider has access to, and will be reviewing my patterns of filling prescriptions through the *Minnesota Prescription Monitoring Program*.

_____ I understand that I may be subject to alcohol and drug screening, and a positive screen may prevent refills and/or result in termination of psychiatric services at Plymouth Psych Group.

_____ I understand the following refill protocol will apply, unless I have made previous arrangements with my provider:

a.) Medication will not be refilled early, even if they have been lost, stolen, or destroyed
b.) I understand that I have to meet with a psychiatric provider to get a refill. There are no “call-in’s” allowed for Controlled Substances.

_____ I agree to keep all appointments with psychotherapy and psychiatric medication provider.

_____ I understand that if I fail to comply with the guidelines in this agreement, my provider or Plymouth Psych Group may terminate psychiatric services.

I have read this agreement, and I fully understand the consequences of violating this agreement. My provider has answered my questions and I agree to the terms of this agreement.

Client Signature: _____ **Date:** _____

Witness/Provider Signature: _____ **Date:** _____

Provider Name: _____