Contract for the Prescription of Controlled Substances

1) I agree to only take my medication(s) as prescribed. This includes how often I take the medication(s) and dose. My provider discussed what I should do if I have questions about the medication or side effects after starting to take it (including conditions where I should stop the medication until I can discuss how to proceed directly with my provider).

2) I have disclosed all of my medications, supplements & vitamins to my provider. I am responsible for updating my provider with any changes to this list.

3) I understand that the medication(s) that I am being prescribed has abuse potential – and that being prescribed this medication puts me at risk for developing a substance problem. I also understand that this medication may cause physiological dependence, tolerance and withdrawal. These side effects and risks have been described to me in detail and I understand the above terms and risks.

4) I understand that my practitioner may require drug testing while under his/her care. Results that are inconsistent with my medical history, medications prescribed or results suggesting that I may have a substance problem (for example testing positive for illegal drugs or medications that I am not prescribed), may be grounds for termination of care at my provider's discretion.

5) I understand that I always have the right to refuse or stop taking my medication(s), but that doing so may result in withdrawal symptoms (with potentially severe medical consequences). If I decide to stop a medication or decrease my dose without direct supervision from my provider, he/she is not responsible for any serious adverse reactions or consequences (including seizure and/or death).

6) If there is concern for medication abuse, diversion (giving or selling the medication to others) or "doctor shopping" (obtaining similar medications from multiple prescribers), my care will be terminated at my provider's discretion. My provider has the right to contact proper authorities (such as the police, DEA etc.) if there is concern that this is occurring. Signing this form gives my provider permission to share my medical record (including drug screens) with any law enforcement agency, medical provider and pharmacy if my provider has a concern. BOSC Mental Health or any of its providers are not responsible for any legal repercussions that I incur, should this occur.

7) My practitioner may contact all of my current and previous providers and pharmacies at their discretion. Reasons include (but are not limited to) notifying them of this contract.

8) <u>If I am not adherent to this contract, honest about my medications and/or doses, do not take medications as prescribed, am not honest with my provider about a history of substance abuse or dependence or do not notify my prescriber should I have concern that I am developing a substance problem, I am solely responsible for any adverse outcomes.</u>

Signing this form indicates that I fully understand all of the above, all of my questions have been answered and I agree to my prescriber's terms for being a patient.

____ __________
Patient Signature - Typing Your Name Here Constitutes Legal Signature Date

____ __________
Witness Signature - Typing Your Name Here Constitutes Legal Signature Date