MAP
MERIDIAN ADVANCED PSYCHIATRY

Controlled Substance Agreement

I, __________________________, understand that the use of a controlled substance medication can cause substance use disorders and carries other risks such as drug interactions, sedation, confusion, poor memory, delayed response time, and impaired coordination. If I am over 65 years of age, I may be susceptible to these side effects. Given the risks associated with these medications, my provider may reduce or safely stop prescribing a controlled substance to me at any time during my treatment based on how I respond to treatment and whether continued use could likely harm me.

While on a controlled substance medication, I agree to abide by the following conditions:

1. Receiving medications from a single prescriber. I will not seek to obtain the same or similar medications from any other prescriber. In case of a situation where I receive a controlled substance from another prescriber, I will notify Meridian Advanced Psychiatry immediately. I will be willing to bring in the entire prescription for a pill count and witness destruction as indicated.

2. Taking the medication as prescribed. I will take the medication at the dose and frequency ordered by my provider. I will not increase the dose or frequency of my medication on my own. I understand that only a small supply of extra doses may be prescribed each month at my provider's discretion. I agree to keep track of my use of these medications and how well they are working for me to share with my provider at appointments.

3. Maintaining regular appointment attendance and participating in consultations. I understand that I must be present at all appointments with my provider. I must also be willing to fully participate in other treatments or consultations, such as psychotherapy, recommended by my provider. If my provider feels that I am not participating in other forms of care as indicated, I may be tapered off my medication.

4. Storing and disposing of the medication safely. I will always store my medications in a secure location. I will prevent access by children or animals to my medication. I will not share or give my prescribed medication to another person, nor will I accept these medications from anyone else. If I have medication remaining that I no longer need (e.g., in the case that my medication is discontinued or changed), I will take it to Meridian Advanced Psychiatry for witnessed destruction. If my medication cannot be safely flushed at the clinic, I will be provided with a list of local destruction sites for medication.

5. I understand that if I require an early refill or replacement, I may be put on increased monitoring such as more frequent appointments, observed dosing, or pill counts. I am not guaranteed an early fill or replacement and may need to be seen in a different setting if I have medical concerns regarding withdrawal, e.g., emergency department.

6. Being responsible for medication supply and refilling on time. I will manage my medication supply by planning and booking my appointments in advance. If I run out of medication early (e.g., by missing an appointment or taking more than prescribed), extra doses may not be prescribed, in which case I will have to wait until my next prescription is due. No refills will be completed outside normal clinic business hours. Refills

are considered at each appointment and arranged to last until my next appointment, by missing or rescheduling appointments I understand I am potentially interrupting my refill cycle and my provider may not be able to refill my medication.

7. I understand MAP has a policy of at least 72 business hours to respond to a refill request and dependent on my individual history, current medications, and request it may require additional time to complete my request. I understand that refills of controlled substances may not be filled after hours, and MAP reserves the right to refuse these requests.

8. Complying with clinic adherence monitoring policies. I understand that my provider may ask me for a urine drug screening sample or a count of my pills at any time. These measures are performed for all patients to improve the safety of prescribing controlled substances. Further refills/prescriptions will be tied to completion of requested screening. Inability to complete these requests will be treated the same as unprescribed substance use/not having the correct quantity of medication.

9. Consent to share information with other health care professionals if medically necessary. I agree to sign any release of information deemed necessary for treatment by my provider. Refusing to do so can result in discontinuing my prescription.

10. Termination of this agreement. If my provider determines that the medication is causing me more harm than benefit, my provider has the right to discontinue my medication safely. I also acknowledge that I could lose my right to treatment from my provider if I break any part of this agreement.

11. Modification of this agreement. My provider may alter this agreement at any time; based on concerns for my safety, my provider may request that I be evaluated more often, provide more frequent urine drug screens, more frequent pill counts, or be provided shorter prescriptions. If I am unable to adhere to this altered plan of care, my provider may not be willing to continue to prescribe a controlled substance for me. Additionally, if my provider is prescribing me a central nervous system depressant such as a benzodiazepine, gabapentinoid, z-drug, or another sedating agent:

12. Not consuming other sedating medications or Alcohol with this medication. Use of CNS depressants with other medications that may cause drowsiness such as opioid pain relievers (including nonprescription codeine) or with alcohol can be serious and life-threatening. Naloxone will not reverse the effects of benzodiazepine overdose. I will not combine my medication with other drugs without consulting my provider first nor will I combine my medication with alcohol.

13. Not abruptly stopping my medication. Discontinuing CNS depressants suddenly after extended use can cause potentially serious withdrawal symptoms. The likelihood of experiencing withdrawal can be reduced by tapering or gradually reducing the dose. I will consult with my provider before stopping my medication to discuss a tapering plan.

I have read the above statements, understand them fully, deny questions and agree to follow them as written.

____ ________________

Patient Signature (18 and older) Date of Birth

____ ________________

Parent/Guardian Signature (if applicable) Today's Date