Psychiatric Professionals of GEORGIA

Your Journey to Wellness

Controlled Substance Agreement

My physician and I have a common treatment goal to improve my ability to function and/or work. In consideration of that goal, I am being treated with medications such as benzodiazepines or barbiturates. These medications may impair my alertness, reflexes, coordination and judgment. The use of these types of medications is controlled and monitored by local, state and federal agencies. These medications can be highly effective when taken as directed under medical supervision, but have the potential of abuse and misuse.

I have been informed that psychological dependence and addiction to controlled substances can occur and are a risk of treatment. If this happens, I will follow my physician's guidance and participate in any treatment programs recommended, which may include medical detoxification, psychological counseling pertaining to substance misuse.

I have never been diagnosed with or treated for a substance use problem.

I have never been involved in the illegal sale, possession or transportation of controlled substances.

I understand that the giving or sale of my prescription medication to any other person is illegal and WILL result in my dismissal from Psychiatric Professionals of Georgia as well as being reported to law enforcement officers.

I have been informed by my psychiatrist and I understand I should not consume alcohol with taking these types of medications.

I take full responsibility for the consequences of driving a motor vehicle, operation of machinery or doing any other activity in which alertness, reflexes, coordination and/or judgment are necessary.

For women: I am not pregnant.

I AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

1. I will follow the treatment plan that my psychiatrist and I have agreed upon.
2. I agree to always be truthful with all my psychiatrist and my other physicians regarding my history, illness, and use of medication.
3. I will report any suspected side effects to my psychiatrist immediately.
4. I understand that my psychiatrist is not obligated, nor will he/she automatically refill prescriptions for controlled medications that I have been receiving from another physician.
5. I will not ask for, nor accept controlled substance medications or prescriptions from any other individuals or physicians while I am receiving such medications from Psychiatric Professionals of Georgia. This is not only **ILLEGAL**, but could endanger my health. The only exception to this would be if I were hospitalized.
6. I will take the medications as directed. If I use my medication up sooner than prescribed, lose my prescription or medication, or if my medication is stolen, I understand Psychiatric Professionals of Georgia will not refill my medication until it is time for the scheduled refill.
7. I will bring the unused portion of my medication to the office for a medication count if requested by my psychiatrist.
8. In the event that my prescription needs to be changed to another medication, I understand I may be asked to return the remaining portion of the prior prescription for disposal.

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9. I understand my medication dosage may need to be increased or decreased depending upon my condition. I will not adjust my medication myself and understand if I need more medication due to a worsening of my condition, I must see my psychiatrist to be re-evaluated before my medication will be increased.
10. I understand that stopping my medications abruptly maybe dangerous and lead to withdrawal symptoms, including increased anxiety, sweats, tremors, nausea, vomiting and possible seizures, hallucinations or confusion. If medications need to be discontinued, I will follow my psychiatrist's supervision.
11. I will submit to drug testing if required, including urine, saliva or hair testing.
12. I authorize Psychiatric Professionals of Georgia and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled medications. I authorize Psychiatric Professionals of Georgia to provide a copy of this agreement to my pharmacy. I also authorize my pharmacy to provide records documenting prescriptions that I have received to Psychiatric Professionals of Georgia, if requested. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
13. I am responsible for keeping track of the amount of medication, and will plan ahead for refills in a timely manner, so I will not run out of my medication. I understand that these types of medications will only be refilled during regular business hours by Psychiatric Professionals of Georgia.
14. For women: am not pregnant and agree to utilize birth control at all times while taking these types of medications. Should I become pregnant, I agree to notify Psychiatric Professionals of Georgia. I will accept the risk to my baby and myself if I should use these medications while pregnant.

My signature below means I have read and understand the terms of this agreement and have had questions answered to my satisfaction. I understand if I violate this agreement, my controlled substance prescriptions and/or treatment will be terminated immediately and I will be dismissed from Psychiatric Professionals of Georgia.

Patient Name (Print): _____ MRN: _____

Patient Signature: _____ Date: _____

Physician Name (Print): _____ Date: _____

Physician Signature: _____