

Consumer Name: _____

Evolv #: _____

BLBHS Outpatient Clinic: Controlled Substance Patient Agreement

I _____, understand and voluntarily agree that:

- I will attend all scheduled appointments at the BLBHS Outpatient Clinic. I will present to the clinic in person for appointments at least once every 3 months for the monitoring of vitals and appropriate medication usage. I understand that BLBHS has a policy that if I miss two or more appointments that I may be required to attend open clinic before being rescheduled with my prescriber. If issues arise and I cannot attend an appointment I will notify the clinic at least 24 hours ahead of the scheduled appointment time and will contact the clinic to reschedule my appointment. Failure to attend appointment may result in my medications being stopped.
- I will ensure that the BLBHS Outpatient Clinic Staff have my most up to date contact information throughout my treatment, including a working phone number and my current address.
- I understand that my medications will not be filled early. If my medications are lost or stolen, **it is my responsibility to report the incident to local authorities and a copy of their report must be presented to the BLBHS outpatient clinic.** The decision for any additional medication dispensing shall solely be made by the prescribing staff.
- I will keep my medicine safe, secure, and out of the reach of children.
- I will not sell my medications or share them with others. Failure to follow this may result in treatment being stopped.
- I will take my medications as prescribed, and will not change the way I take my medication without consent from my prescriber prior to doing so.
- I agree that I will participate in all types of services that I am asked to participate in, including assessments, urine drug screenings, and random pill counts. ****A urine drug screen has many purposes and is mainly used to verify that in fact an individual is taking DEA controlled medications as prescribed. It also establishes whether in fact an individual is using other substances or illicit drugs that may impact a person's mood, behavior, and response to treatment. It is at BLBHS prescriber discretion to stop medications that we believe may be harmful or interact with these substances.**
- I agree that I will participate in supportive services such as Blended Case Management or Drug and Alcohol Treatment programs that I am referred to (insurance permitting).
- I will treat the staff at the clinic respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment may be stopped.
- I will sign a release form allowing the prescribing staff, nurses, or assistants speak to all other doctors, providers, and/or pharmacies that I work with.
- I will tell my clinician about all other medications that I take, and let him/her know right away if I have a prescription for a new medicine from another provider. I understand that failure to do so may result in treatment being stopped.
- I understand that if I am prescribed any opiate or opiate replacement medication that I **will not** also be prescribed a benzodiazepine medication, due to unsafe risks of combining these medications.
- I understand that the prescribing team reserves the right to discontinue the prescription of controlled substances for consumers who are utilizing medical marijuana, to ensure best practice standards, safety, and effectiveness of my medication regimen.
- I will not use illegal drugs such as heroin, methamphetamine, marijuana, or cocaine. I understand that if I do, my treatment may be stopped.
- I understand that changing primary clinicians throughout treatment is solely at the discretion of the clinical staff. If I have a disagreement with my clinician I can request an internal psychiatric review of my records. I understand that I will not be present for this review but am able to provide written documentation to be considered. I am able to request the results of this review, which may be provided to me in writing.
- I understand that if I am prescribed a controlled substance at another facility and I establish care at BLBHS, this medication will not continue to be refilled at BLBHS, and a release of information to communicate with the current prescriber will be required for collaboration purposes. Furthermore if medication is being prescribed at another facility for pain or other

Consumer Name: _____

Evolv #: _____

physical health purposes it will not be considered for prescription via BLBHS. Purposefully misleading BLBHS prescribers about controlled substances you may be receiving from other providers may be grounds for our prescribers to not provide prescriptions for controlled substances and/or termination of treatment.

BLBHS statement of prescribing controlled substances, such as benzodiazepines and/or stimulants:

BLBHS outpatient clinic is committed to working with you in your efforts for recovery. BLBHS prescribers are committed to provide the most effective and safest treatment to our clients. We will take certain safe guards to protect each consumer and that may also prevent us from prescribing potentially harmful or deadly combinations of medications or substances. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to change or cancel your appointment for any reason, we will make sure you have enough medications to last until your next appointment.

We will make sure that this treatment is as safe as possible, and will prescribe within the FDA limits for indicated safe dosages (unless your clinician indicates a need to prescribe outside of FDA limits, at which case your record may be subject to an internal review). We will also prescribe these medications for the shortest duration possible and will check regularly to make sure you are not experiencing side effects to the medications.

We will keep track of your prescriptions, and test for prescribed drug levels of the medications you are given, to monitor your progress with these medications.

We will help connect you with other providers available to assist you with your overall wellness. Your treatment team will help you in developing treatment goals and monitor your progress in achieving these goals.

We will work with any other doctors or providers you are seeing so that we can work as a team to treat you safely and effectively.

Consumer signature

Date

Consumer printed name

Provider signature

Date

Providers name printed