OPTIMAE BEHAVIORAL HEALTH SERVICES

CONTROLLED SUBSTANCES AGREEMENT

The purpose of this agreement is to explain what Optimae expects when patients are prescribed controlled medications, like stimulants (Adderall and Ritalin for example) and benzodiazepines (like Alprazolam, Clonazepam, and Temazepam). It is to help both you and your provider comply with the law regarding controlled medications, and is essential to the trust and confidence necessary in a physician/patient relationship.

By signing this document, I agree to the following:

1. **CONTROLLED MEDICATION RESTRICTIONS:** I will not share, sell, or trade my medications. I am aware that selling my controlled medications in the state of Iowa is a felony offense. I am also aware that changing a written prescription or misleading a pharmacy is an aggravated misdemeanor offense, and if another person is found to have unlawful possession of my controlled medications, they may be charged with a misdemeanor and could lose their driving privileges.

2. **PROTECTING MEDICATIONS:** I will safeguard my medications from loss or theft, and I understand that lost or stolen medications **will not** be automatically replaced. (To reduce instances of medication loss/theft, we recommended that you carry only the amount of medications that you will actually need when away from home.)

3. **SINGLE PROVIDER:** I will not try to get controlled medications that Optimae prescribes (controlled stimulants, or antianxiety medications) from any other providers unless Optimae Behavioral Health has given me written permission to do so.

4. **COOPERATION WITH THE TREATMENT PLAN:** I will communicate fully with my provider about the type and intensity of my symptoms and the effects they have on my daily life. I will work with my provider to establish a treatment plan, and I realize that I may be asked to participate in treatments other than medication management, such as therapy, self-help programs, and psychological testing.

5. **PHARMACY:** I agree to use one pharmacy for all my controlled prescriptions (written below). If I do decide to change pharmacies in the future, I will inform an Optimae Behavioral Health nurse.

_____	_____
(NAME OF PHARMACY)	**(LOCATION OF PHARMACY)**

6. **REFILLS:** I understand that refill requests for my controlled prescriptions should be made at the time of an office visit or during regular office hours of my provider. I also understand that not going to scheduled appointments may cause me to run out of my medications

7. **PERMISSION FOR COLLABORATION:** I agree to allow my provider, or authorized staff member, to communicate with any current or previous provider or pharmacy regarding my use of controlled substances at any time during the course of my treatment.

8. **PRESCRIPTION MONITORING PROGRAM:** I am fully aware that my provider may review my history of controlled prescriptions using the Iowa Prescription Monitoring Program database to determine whether I have obtained prescriptions from other providers and or whether I have filled my controlled prescriptions early.

9. **COOPERATION WITH INVESTIGATIONS:** I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State Board of Pharmacy in the investigation of any possible misuse, sale, or other diversion of my pain control medications. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentiality with respect to these authorizations.

10. **DRUG TESTING:** I agree to submit to a blood, saliva, or urine test **at my cost** if requested by my provider to determine if I am taking my medications as prescribed and that I am not using illicit drugs. I understand that refusal to submit to this test may result in the **immediate termination of care** by my provider.

11. **MISUSE OF MEDICATIONS:** I agree that I will use my medications as prescribed, meaning that I will not take them more often than prescribed, or take more at a time than prescribed. I also understand that not following my prescription instructions exactly could result in my running out of medications before the next refill time, and that I will not be allowed to fill my next prescription early.

12. **UNDERSTANDING THIS AGREEMENT:** I agree that all terms of the Agreement have been fully explained to me and I understand all terms of this Agreement. All of my questions and concerns regarding treatment have been adequately answered. Copies of this signed Agreement will be given to me and placed in my medical record.

13. **VIOLATION:** I understand that if I break this Agreement, my provider may stop prescribing these controlled medications, and may even terminate my care. If I must be taken off of my controlled medications for a violation of the agreement, my provider will choose whether to taper me off of my medications, or discontinue the controlled medications and prescribe medications to treat the withdrawal symptoms.

THIS AGREEMENT IS ENTERED INTO ON THIS DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____

PATIENT NAME: _____

--------THIS AGREEMENT DOES NOT EXPIRE--------