Balance
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balancewomenshealth.com

Controlled Substances Agreement

Controlled substance medications (i.e. narcotics, tranquilizers, barbiturates, stimulants and hormones) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. As a patient of Balance Women's Health, I agree to the following:

___ 1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

___ 2.) Refills of controlled substance medications will be made only during regular office hours Monday through Friday, in person, once a month, and preferably during a scheduled office visit.

___ 3.) I may be asked to complete routine urine testing.

___ 4.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

___ 5.) I understand that I am given medications to assist in reaching treatment goals. I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

___ 6.) I understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

I have been fully informed regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms. By signing below, I understand and accept the above treatment agreement.

Patient Signature: _____Date:_____

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