



Long Term Use of Controlled Substances Agreement

PATIENT AND SECLAIRER EXPECTATIONS:

- **Comprehensive treatment plan:** I understand that taking controlled substances is only one part of my overall treatment. The renewal of my controlled substance prescriptions depend on both my medical needs and my consistent participation with the overall prescribed treatment plan that includes; physical-lifestyle counseling, individual therapy for behavioral changes and DBT Skills Group for behavioral skills training. I agree to participate in my prescribed treatment each week as prescribed by my provider.
- **Use of medications:** I will take **ALL** controlled substances exactly as prescribed to me. This means I will not change the dose, frequency, or alter the form of drugs themselves (such as opening capsules, cutting in half, crushing, or chewing medications.) I understand that increasing the dose of frequency of any medication, including controlled substances, or altering its form, may result in harmful effects including overdose.
- **Seclairer policy dictates refills:** My provider will only refill my prescriptions consistent with Seclairer’s policies and procedures.
 - 1) **My provider will not fill any prescriptions early** if I run out of controlled substances before my scheduled refill or appointment.
 - 2) My provider will only renew my controlled substance prescriptions **during a scheduled office visit.**
 - 3) My provider will not replace lost, stolen, damaged, or otherwise rendered useless controlled substances or controlled substance prescriptions.
- **Compliance with appointment schedule:** I agree to attend **ALL** scheduled appointments **in person** in order to obtain my controlled medications.
- **Drug testing:** I agree that my provider may order me to be tested for drug use at any time at their discretion. I agree to comply with any and all drug tests, instructions, and pill counts that may be ordered by my provider, including, but not limited to, urine or blood.
- **Risks of birth defects (female patients):**

If you are not pregnant: My provider has explained the risks to my unborn child if I become pregnant while taking controlled substances. I have also been informed of the importance of using safe and effective birth control while taking controlled substances. **If I become pregnant, I will notify my provider immediately.**

If you are pregnant: I have informed my provider of my pregnancy. I acknowledge that I have a complete understanding of the risks of taking controlled substances while pregnant. I have chosen to take controlled substances despite these risks.
- **Illegal drug use and/or activity:** I will not use any illegal substances/drugs or prescription drugs obtained through illicit means and I will not share, sell, or trade any medications, including controlled substances prescribed by my provider with anyone.
- **Use of alcohol:** I acknowledge that I have a complete understanding of the risks of consuming alcohol while taking controlled substances. Should I consume alcohol while taking controlled substances prescribed to me, I do so despite the risks.
- **Authorization to share protected health information:** I authorize my provider to cooperate fully with any city, state, or federal law enforcement agency (including the DEA), and to disclose my medications or possible misuse with any pharmacy, legal authority, or regulatory agency at his/her sole discretion.
- **Termination of treatment at Seclairer:** I acknowledge that my provider may at his/her sole discretion stop treating me with controlled substances, and terminate my patient status if I break any portion of this agreement or am arrested for any unlawful conduct.

Due to changes in **DEA REGULATIONS** we are enforcing a new policy here at Seclairer. If you are prescribed or will be prescribed any controlled substances, and you are out of your medications, you will **NOT** receive a script without being seen for an office visit, exceptions/emergencies treated on an as needed basis.

My signature confirms that I understand and agree to all of the requirements of the controlled substances agreement.

Patient full name: _____

Date of birth: _____

Patient signature: _____ Date: _____

I have received a copy of the controlled substances agreement. Patient initial: _____

Seclairer witness signature: _____ Date: _____