MURRAY, WILSON & ROSE
COUNSELING AND BEHAVIORAL SERVICES

Controlled Substance Agreement and Informed Consent

Please complete this form to indicate that you understand your responsibilities as a patient who may be prescribed a controlled substance. Signing this form indicates your understanding and agreement to follow these guidelines.

I agree to do the following:

- I will only receive prescriptions from my provider's office.
- I will complete formal testing (or show proof of testing) if my provider requests it.
- I will get records from my past providers sent to my current provider.
- I will only get my medication(s) from the pharmacy named below.
- I will tell my provider immediately if I need to change pharmacies, permanently or temporarily.
- I will ask for a refill at least three days before it is due. I know that my medication being filled may be delayed by the completion of a prior authorization needed by some insurance carriers.
- I will take my medication as directed, and only as directed.
- I will tell my provider if I receive controlled substance medication or prescriptions from another provider, such as a specialist, or from the emergency room.
- I will allow my provider to check my urine or blood to see what drugs I am taking. We may discuss whether or not this is on a scheduled basis, per provider.
- I will attend all my scheduled appointments, with both my provider and other identified members of my care team, such as a therapist, and be on time to all appointments. I will follow all office guidelines and procedures when at the office, and I will follow all virtual guidelines when being seen via telehealth.
- I will call my provider's office at least 24 hours in advance if I need to reschedule an appointment.
- I will tell all of my other medical providers that I have been prescribed and am currently taking a controlled substance.
- I will tell my provider about my medical history and current medical problems, and will answer all questions they have truthfully.
- I will allow my provider to talk with my other health care providers about my health or any concerns, and will complete releases of information for all other healthcare providers.
- I will keep my medication in a safe place and keep it away from children, vulnerable adults, and pets.

- I will take appropriate steps, including contacting law enforcement if appropriate, right away if my medication is lost, stolen, or goes missing.
- If I am pregnant currently or if I become pregnant, I will notify my provider immediately. I understand that use of controlled substances may increase the risk of harm to the fetus.

I agree that I will not do the following:

- I will not share, trade, or sell my medication with anyone.
- I will not use medication that has not been prescribed to me.
- I will not use drugs while taking this medication, including, but not limited to, cocaine and methamphetamines.
- I will not change how I take my medications without talking to my provider.
- I will not ask my provider for extra refills if my medication is lost or stolen.

I understand the following:

- A copy of this agreement may be given to my designated pharmacy.
- This medication is part of a larger treatment plan. Controlled substance medications will only be given to me if they can be used safely in conjunction with my treatment plan.
- When being prescribed a controlled substance for the first time, it is a test to see if it will help. My provider will only continue to prescribe this medication to me if it continues to help.
- My provider decides when and if I will be given refills of a controlled substance.
- My medication may require an in person (or telehealth) appointment to renew my prescriptions.
- My provider and my pharmacy may work with the police to look into any misuse or sale of my medication.
- I understand that a delay in my provider receiving past records or results from testing may delay receiving my medication. It is my responsibility to ensure that these records or results are received by my provider.
- I am responsible for setting up any further testing needed as directed by my provider.
- If I yell at, swear at, or otherwise harass my provider or the staff at my provider's office, I may be dismissed as a patient.
- If I use a different name to receive a medication or sell my medication, this may be reported to the police.
- If I choose to consume alcohol while taking my medications, I know there could be dangerous side effects, including possible death.

Failure to comply with the agreed upon terms may result in the cancellation of your prescribed controlled substance, dismissal as a patient, legal charges, or serious side effects from the medication.

By signing this form, you acknowledge that you have asked any relevant questions and that you understand that your provider will explain to you the potential side effects, as well as the risks, benefits, and other treatment options available to you.

Designated pharmacy (include street address):

Designee for medication pickup:

Signature: _____ Date: _____

Would you like a copy of this informed consent? Yes ▢ No ▢