SNBCare
Spectrum Neuro Behavioral Care

Patient Agreement for Controlled Substance

PATIENT NAME: DATE:

I agree to the following:

- I agree to keep my medication in a safe, secure location and away from children. If the medication is lost or stolen, I understand that I will need to bring in a police report and the medication will not be replaced, if at all, until my next appointment.
- I agree to have urine or blood tests as directed. I understand that testing positive for any illicit drugs or any medication that is not being prescribed to me is a violation of this agreement.
- I agree to not sell or share my medication with anyone else.
- I agree to keep all my scheduled appointments. If I am not able to attend, I will provide 24 hour notice and will reschedule within seven days. I understand I will not get my medication called in for more than 7 days.
- I agree to take my medication only as prescribed and will not take more unless I have addressed it with my provider and it has been approved.
- I agree to notify my provider of any new medication that is prescribed by another doctor, including suboxone or methadone.
- I will treat the staff at the office respectfully at all times. I understand that if I'm disrespectful to staff or disrupt the care of other patients that my treatment may be stopped.
- If I am on high doses of a controlled substance, I agree to slowly and safely reduce dosage as per the guidance of my provider.
- I understand that my provider is under no obligation to continue prescribing any controlled substance medication if I do not attend follow-ups as scheduled.
- I understand if I am on controlled substances, I will be seen monthly by my provider.

Refills

Refills will be made only during regular office hours and 72 hour notice must be provided. There will be no refills after office hours, weekends, or during holidays.

Termination of Agreement

I understand that if I do not adhere to this office policy, this medication may be stopped in a safe way. I understand that if I do not adhere to this office policy, controlled substances may not be refilled by my provider.

Patient Signature:

Date: