LIGHTHOUSE PSYCHIATRY
ADVANCED TMS & COUNSELING
a beacon for recovery and discovery
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BEHAVIORAL HEALTH CONTROLLED SUBSTANCE AGREEMENT

The purpose of the agreement is to prevent misunderstandings about prescription medications that have the potential for abuse and dependence. These medications fall into two different categories:

A. Anti-anxiety medicines used for the treatment of anxiety, panic and insomnia.
B. Psycho-stimulant medicines used for the treatment of attention deficit disorders and depression.

I UNDERSTAND AND ACKNOWLEDGE THAT I FULLY COMPLY TO STIPULATIONS LISTED BELOW FOR ME TO RECEIVE MEDICATION TREATMENT AT CLINIC.

1. I understand that if I am prescribed medications that fall into those categories listed above, I will be assessed at risk for abuse or dependence.
2. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. My doctor will provide treatment to me based upon this Agreement.
3. I understand that if I break this Agreement, my doctor may stop prescribing these medications. In this case, my doctor may taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence program may be recommended.
4. I will NOT use any illegal controlled substances, including cocaine, methamphetamine, etc.
5. I will NOT attempt to obtain anti-anxiety medicine or psycho-stimulants from any other doctor.
6. I will notify my doctor immediately if I obtain controlled substances as such as pain medications, including medical marijuana, from any other doctor.
7. I will NOT share, sell or trade my medication with anyone.
8. I will safeguard my prescriptions and controlled medications from loss or theft. Lost or stolen medicines will not be replaced.
9. I understand that my doctor cooperates fully with the Arizona Board of Pharmacy, Controlled Substance Prescription Monitoring Program (AZ CSPMP). My doctor will use information provided by the AZ CSPMP in making decisions regarding my medication choices.
10. I agree I will submit to a blood or urine test, if requested by my doctor, to determine my adherence with my medication and with this agreement.
11. I agree I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
12. I agree not to mix my medications with alcohol.
13. I agree to designate the use of one pharmacy. Refills will be obtained by written prescription only, during regular office hours.
14. I agree to follow these guidelines that have been fully explained to me.
15. **I understand and acknowledge that I will be discharged from receiving medication management if I compromise any stipulation above.**

All of my questions and concerns regarding treatment have been adequately answered. A copy of this Agreement has been given to me.

By signing this document (by paper or electronically), I have read, understand, and agree to the terms above. I agree that photocopies of this document are as legally binding as the original copy.

Patient Name	Patient Signature	Date
Guardian Name (if applicable)	Guardian Signature	Relationship