SHIFA Health

Informed Consent and Agreement for Treatment with Controlled Substances

I, _____, understand and agree to the following policies::

1) I will take medications only at the dose and frequency prescribed.

2) I will protect my prescriptions and understand that lost or stolen controlled substances may not be replaced.

3) I will inform this provider of all other medications that I am taking, including street drugs.

4) I understand that if I miss my suggested follow-up appointment, refills may not be provided to me.

5) I agree to use one designated pharmacy for my medications (I will inform the office if I need to change).

6) I understand that I may be required to take a drug test or substance abuse evaluations at the discretion of my provider.

This prescriber may stop prescribing controlled substances and/or other medications for me if:

1) I obtain any controlled substances including tranquilizers, hypnotics, or stimulants from sources other than this provider.

2) I consistently miss my follow-up appointments or reschedule.

3) I develop rapid tolerance or lack of improvement from treatment.

I understand that any violation of this agreement may pose a health risk to myself and/or others and may result in a discontinuation of treatment if deemed medically prudent.

I will not hold the provider responsible for withdrawal symptoms that may occur if I do not take medications as provided, or if I fail to come for suggested follow-up appointments.

I have read this document, understand it, have had all questions regarding risks and conditions of the agreement answered satisfactorily, and I agree to all of its elements.

Patient Signature: _____ Date _____

Health Care Provider Signature:_____ Date_____