MONARCH
HEALTH & WELLNESS

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CONTROLLED SUBSTANCES TREATMENT AGREEMENT

I,_____ (patient) of **Michelle Carlin**, **NP**, have been informed that controlled substances such as benzodiazepines, wake promoting agents, sedative hypnotics, and stimulants, may be useful to utilize in my treatment plan. While controlled substances are intended for therapeutic purposes in order to improve my functioning, these medications can have a high potential for misuse and abuse. Therefore, they are closely monitored by the state and federal government. I understand that **Michelle Carlin**, **NP** participates in the Arizona Prescription Drug Monitoring Program in order to ensure safe use of controlled substances. I agree to follow the rules and procedures of this agreement in order for **Michelle Carlin**, **NP** to consider prescribing controlled substances to me.

1. I agree to take the medication as prescribed and not to share my medication with others as this is **illegal and dangerous.**
2. I understand all requests for controlled substance medication refills must be anticipated and made **during regular business hours.**
3. I understand that my prescription may not be refilled early if the controlled substance is lost, stolen, or used up sooner than prescribed. If any of these situations arise causing me to request an early refill, further documentation will be requested which may include a police report.
4. I understand that all prescriptions of controlled substances will be filled at only one pharmacy and that it is my responsibility to notify the office if this pharmacy needs to be changed. I give the pharmacy permission to release information about prescription medication I am taking or were previously taking.
5. I understand that my mental status will be assessed and monitored on a regular basis to see how my treatment plan is working. Renewal of prescriptions, if indicated, is contingent upon attending my prescriber appointments regularly.
6. I agree to allow my provider to order any laboratory or diagnostic testing needed to ensure the medication is being taken correctly and in a therapeutic manner. I understand that if I refuse to complete the tests, or there are signs of misuse or illicit substance use that the medication may be discontinued.
7. I understand that there is a risk of my body becoming physically dependent on this medication and that the medication alone can cause impaired thought processes. This risk is heightened if I use other controlled substances, alcohol, or illicit substances at the same time which can result in death.
8. I agree to notify my prescriber of all medications that I am currently taking and to allow my prescriber to coordinate care with all of my health care professionals, including but not limited to my primary care provider, specialists, dentist, or therapist.
9. I understand that evidence of drug seeking behavior or prescriptions of controlled substances from other prescribers may result of termination of my medical care.

Patient Signature _____ Date _____

Prescriber Signature _____ Date _____