NEW PATH PSYCHIATRY

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Controlled Substance Agreement Form

I, ____, understand and agree to the following terms regarding the prescription and use of controlled substances in my treatment:

I acknowledge that I have been informed about the risks and benefits of controlled substances, including the potential for addiction, dependence, and overdose.

I understand that my provider may request blood work and urine drug screens as part of my treatment plan, and I agree to comply with these requests.

I understand that my provider is not obligated to restart or continue medications prescribed by other healthcare providers. Any decisions regarding medication changes will be discussed during my sessions.

I agree not to seek or obtain the same medication from other healthcare providers while under the care of ___________________________________.

If I require new medication prescribed by another healthcare provider (PCP or ER), I will promptly inform my provider via the patient portal or email.

I understand that Colorado state law regulates the prescription and use of controlled substances, and I agree to adhere to all applicable laws and regulations.

I acknowledge that my provider will review my prescription history through the Prescription Drug Monitoring Program (PDMP) to ensure safe and appropriate prescribing practices.

I agree to inform my provider at least one week before running out of medication to ensure timely refills. Early refills will not be provided for misuse or loss of medication.

I understand the potential dangers of controlled substances to my health and well-being, and I will use them responsibly as prescribed.

I hereby confirm that I have clarified with my provider that I have no cardiac history and no family history of cardiac illnesses such as heart attack and stroke.

I, [Patient's Name], have read and understand the terms outlined in this Controlled Substance Agreement Form. I agree to abide by these terms for the duration of my treatment with __________________________

Patient Signature: __________________________ Date: ________________

Provider Signature: __________________________ Date: ________________