Counseling Center of New Smyrna Beach

Angelique McLoughlin ARNP, PMHNP-BC • Brianne Ward ARNP, PMHNP-BC • Chrystel Hart ARNP, FNP-C, PMHNP-BC
136 Julia St. #100, New Smyrna Beach, Fl. 32168 (P) 386-423-9161 (F) 386-423-3094

Agreement for Prescribing of Controlled Substances

I will be prescribed controlled substances only if I understand and agree to the following:

-I understand that depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly.

-Controlled substances can cause sedation, confusion or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am sedated, feel drowsy or not thinking clearly.

-I will not use any illegal controlled substances including, but not limited to marijuana and cocaine. I will not use alcohol to excess.

-If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medications early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

-I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. The doctor expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy of the police report at my next office visit.

-My physician will prescribe whatever medication he/she is comfortable with and thinks is best; he/she is not under any obligation to prescribe any specific medication.

-I agree to come to my physician with my medication on the same day that I am called and submit to a pill count, and/or blood or urine screening to detect illegal substances or confirm proper use of prescribed medication. The call to come in to see the physician can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

-I give permission for the doctor to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances, other medications or any issue regarding my medical care and condition.

-My physician can wean me of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms.

-I understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and /or transport with the intent to sell or dispense my medication.

I have read the above Agreement, understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this agreement.

_____ _____

Patient (Print) Date

_____ _____

Signature (Self/Parent /Guardian) Date

_____ _____

Physician Signature Date