



Wadsworth Psychiatric Services, PLLC
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Controlled Substance(s) / Medication Refill Policy

Controlled substance medications (i.e. benzodiazepines, opioids and amphetamines) are very useful, but have a high potential for misuse. Controlled substances are closely controlled by local, state and federal authorities. As a patient of Wadsworth Psychiatric Services, you agree and understand the following **(initial each section)**.

I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if misused. I understand that this medication will not be replaced regardless of the circumstances.

Initial _____

Refills of controlled substance medications:

a. Will be made only during regular office hours Mon-Fri, once a month, and during a scheduled office visit, unless otherwise agreed upon. Refills will not be made at night, weekends or on holidays. I will not call on Thursday afternoon requesting a refill.

b. Will not be made for lost, misplaced or misused medications. The security, management and proper usage of controlled medications are the sole responsibility of the patient / and or guardian.

Initial _____

I agree to comply with urine drug testing and pill counts on request, thereby documenting the proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.

Initial _____

I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

Initial _____

I understand that if I violate this policy due to non-compliance of medical direction resulting in misuse or abuse of prescribed medications or illicit drugs, I may be subject to dismissal from care at Wadsworth Psychiatric Services.

Initial _____

I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in the office.

Initial _____

I agree to not sell, share, give away or divert my medications into any form of misuse or abuse. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

Initial _____

I agree to not obtain medication from any doctors, pharmacies or other sources without informing my treating clinician.

Initial _____

I agree to take my medication as my clinician has instructed and not to alter the way I take my medications without first consulting my doctor.

Initial _____

I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine and other addictive substances.

Initial _____

I agree to fill my controlled medication at an in-state (Washington) pharmacy. I will list my pharmacy of choice and understand I must use this pharmacy. I understand that prescriptions will not be re-written if I am not satisfied with the manufacturer of the medication given to me at my pharmacy Initial _____

I understand that Wadsworth Psychiatric Services utilizes Washington State Prescription Drug Monitoring Program and will monitor my prescription history via this source. Initial _____

Pharmacy Name _____ Pharmacy phone _____

I have been fully informed of the above treatment agreements and have a full understanding of my duties as a patient of Wadsworth Psychiatric Services in regard to the controlled substances and any subsequent refills.

Patient Name _____

Patient/Guardian

Signature _____ Date _____

Physician Signature _____ Date _____