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Agreement for Use of Controlled Substances

To Be Prescribed a Controlled Substance, You Must Agree with the Following Statements:

1. I will not allow other individuals to take my medication.

2. I will obtain all stimulant (ie. Adderall) and/or benzodiazepine (ie. Xanax) prescriptions from Dr. Louie.

3. I will actively participate in additional therapies as requested by Dr. Louie.

4. I have informed Dr. Louie if I have or have ever had, a problem with substance abuse or dependence.

5. I am not involved, nor have I ever been involved, in the sale, illegal possession, diversion, or transport of controlled substances.

6. I understand that lost or stolen prescriptions or medications will not be replaced.

7. I will agree to participate in a program for chemical dependency should a problem be identified.

8. If I am a female of child-bearing age, I will inform my physician if I become pregnant.

9. For "No Show" appointments, medications will not be refilled until the next available appointment.

10. I will keep all medications out of the reach of children.

I Understand That Prescriptions for Controlled Substances May Be Discontinued or I May Be Discharged from Dr. Louie's Care If Any of the Following Occur:

1. Dr. Louie feels that the controlled substance(s) has not produced effective relief or improved level of function.

2. I give away or sell the medications.

3. I allow my medications to be stolen.

4. I lose/misplace the prescriptions or medications.

5. I do not follow instructions and take more medications than is prescribed.

6. I obtain prescriptions for controlled substances already prescribed by Dr. Louie from other sources.

7. I use illegal substances (narcotics, marijuana, cocaine, etc.).

8. I do not keep appointments with Dr. Louie.

9. If I commit prescription fraud.

I have read this document and understand it. All of my questions have been answered by Dr. Louie.

I consent to the use of controlled substances as part of my treatment and understand that my treatment with any controlled substance will be carried out in accordance with the conditions stated above.

I understand that if I do not follow the conditions of this contract, I can endanger my health as well as my life. I also understand that any infractions of the above conditions may result in my immediate discharge from Dr. Louie's practice.

Patient Signature:_____

Today's Date:_____