Bridge Health Services
601 S. Rancho Dr. Ste. D29, Las Vegas, NV 89106
Phone Number: 7028430551
Email: bridgehscg@gmail.com

PATIENT NAME: _____ DOB: _____

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. Benzodiazepines, Hypnotics (Non-Benzodiazepines), and Stimulants) are very useful for controlling both acute and chronic **Anxiety, insomnia and ADD/ADHD** respectively. They all have a high potential for misuse and are, therefore, closely controlled/monitored by local, state, and federal governments. They are intended to relieve symptoms of the disorders stated above, thus improving quality of life, function and/or ability to work. Because my provider is prescribing controlled substance medications to help manage my symptoms in regards to my diagnosis, I agree to the following conditions.

TREATMENT GOALS

1. I understand that the treatment goal is to reduce my symptoms to a manageable level and improve the quality of my life.
2. In consideration of this goal, and because of the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by practicing healthy life choices such as increase in activity and exercise, weight control, and avoidance of tobacco, Marijuana and alcohol.
3. In addition to healthy habits, I will also attend psychotherapy as recommended by my provider.
4. I must also comply with the treatment plan as prescribed by my provider.

PATIENTS' RESPONSIBILITY (Please initial next to each responsibility)

_____I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it will not be replaced.

_____ I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical/Psychiatric care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.

_____ I will use only one pharmacy for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.

____ I know that telephone refills are not allowed. **Calls or faxes from pharmacies to refill medications will not be authorized.**

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____ I agree to random PILL COUNT to monitor medication usage. I understand that if the provider feels that I am at risk for psychological or physical dependence (addiction); my medications may be tapered off within 7 days. These will be performed during regular office hours. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for discontinuation of prescribed controlled medication. Patients who fail to show for random pill counts will be immediately terminated from the practice.

____ I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State while taking the prescribed medications.

____ I agree to undergo **random urine drug testing within 24 hours of office visit** at the discretion of the provider. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for medication taper to completion.

____ I will not request or accept same or similar form of controlled medications from any other physician while receiving treatment from this office. **I will not give, share or sell my medications to any other person.**

____I will turn in ALL medication prescriptions within 2 weeks after receiving them. If after 2 weeks the prescription expires, I will return the expired scripts before a new script can be written.

REFILLS OF MEDICATIONS

____Will be made only during regular office hours Monday through Friday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays. No telephone Refills to pharmacy.

____Will not be made if I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid theft.

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RISKS OF THE CHRONIC BENZODIAZIPINE USE

I understand that the long-term advantages and disadvantages of chronic Benzodiazepine use have yet to be scientifically determined. My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate. I am aware that tolerance to controlled medications means that I may require more medicine to get the same amount of symptoms relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to medications may force my doctor to choose another form of treatment.

RISKS OF THE CHRONIC STIMULANT USE

I understand that the long-term advantages and disadvantages of chronic Stimulant use have yet to be scientifically determined. But research finding suggests the following:

____ Cardiovascular complications may appear earlier in older adults receiving maintenance stimulants treatment. Because the way amphetamines work in the body differ between children and adults, evaluation of the potential for adverse effects of chronic treatment of adults is essential and warrants **YEARLY EKG TESTING**.

____ Stimulant long-term use may pose a risk on the growth of children due to reduced caloric intake in view of the decrease in appetite associated with these drugs.

____Although most adult patients also use stimulant effectively and safely, occasional case reports indicate that prescription use can produce marked psychological adverse events, including stimulant-induced psychosis and Mania.

RISKS OF THE CHRONIC HYPNOTIC USE

I understand that disadvantages of chronic hypnotic use have been scientifically determined. And the research finding suggests the following:

____Chronic hypnotic use is strongly associated with insomnia, poor function, and poor quality of life.

____ Chronic use of hypnotics may create sleep and performance problems, memory disturbance, driving accidents, and falls.

____There is no persuasive evidence that long-term use of hypnotics produces any benefit. Rather, the risks of chronic hypnotic use outweigh the benefits, which is why I will be prescribed hypnotics temporarily.

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RISKS OF CONCOMITANT USE OF CONTROLLED SUBSTANCES

The concurrent use of opioids (Morphine, Oxycodone, Percocet, Tramadol, Hydrocodone, Dilaudid etc), benzodiazepines (Xanax, Ativan, Clonazepam, Diazepam), Hypnotic (Ambien, Temazepam, Halcion, Lunesta, etc), alcohol, marijuana and other illicit drugs poses a higher risk of adverse events, overdose, and even death. To improve patient outcomes, ongoing screening for unusual behavior, monitoring of treatment compliance, documentation of medical necessity, and the adjustment of treatment to clinical changes are essential.

(FEMALE PATIENTS ONLY)

____I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

ACKNOWLEDGEMENT OF INFORMATION

I have been fully informed by my provider regarding the potential for psychological and physical dependence (addiction) of controlled substance medications and risk of chronic use of these medications. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under my provider's supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are used inappropriately.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice, I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. I am responsible for any withdrawal syndrome that may occur due to my misuse of the narcotic medications and/or termination of my care. I have read this contract and the same has been explained to me by my provider and the office staff. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Date_____ Patient_____

Witness_____