LINK HOUSE INC.
PROVIDING THE TOOLS TO MAINTAIN LONG-TERM RECOVERY

CENTER FOR BEHAVIORAL HEALTH & ADDICTION TREATMENT SERVICES

Name: _____ DOB: _____ Date: _____

CONTROLLED SUBSTANCE AGREEMENT

This agreement will help you and your Link House CBHATS medication prescriber ensure that you receive the best treatment possible, especially by concerning your prescribed controlled substances.

Controlled substances have the potential to be misused or even abused. Consequently, we want to make sure that you understand and agree to the terms below. Your CBHATS prescriber will evaluate how you are feeling while taking these medicines and s/he may change the prescription or treatment plan if you have problems such as side effects, if you're not helped by the medicines, or if you don't follow the rules of this agreement.

1. My prescribed medication(s) will only be prescribed by the prescriber signing this contract, or designee.
2. Controlled substances will be filled at one pharmacy. If I choose a different pharmacy, I will contact CBHATS. My prescriber or designee may speak with the pharmacist about any testes or treatment plans.
   Pharmacy Name: _____
   Pharmacy Address: _____
   Pharmacy Phone: _____
3. I will tell my CBHATS prescriber about other prescribed medications and if I have adverse effects.
4. I will not share or sell my medicine.
5. My urine or blood will be tested from time to time to ensure I am taking the medication as prescribed.
6. If there are drugs that I shouldn't be taking in my urine or blood test, I understand that my prescriber may stop my medication and I will be referred for mental health and/or drug treatment/counseling.
7. I understand that all medicines can be dangerous if taken by others, especially children, and I will keep my medicines secure and away from others.
8. I understand that I must keep my medicines in the bottle(s) that I get from the pharmacy and bring the with me to my CBHATS medication refill appointments.
9. If anything happens to my medication, my CBHATS prescriber will not provide a replacement prescription.
10. I understand that I will not be given an early refill for any reason.
11. If I don not keep my medication appointments, my prescription may not be refilled.
12. I understand that I will not get any refills after clinic hours, on weekends, or holidays.
13. I have been given the opportunity to ask questions about this agreement and have had all questions answered to my satisfaction.
14. My signing this agreement means that I understand and agree to follow the rules.
15. I understand that if I do not follow these agreement rules, my prescriber will stop prescribing my controlled medicine.
16. This agreement will remain in effect at all times while a controlled substance is being prescribed to me by a CBHATS prescriber.

Client Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____