Lifespan Behavioral Health Services PC Controlled Substances Agreement

Please initial each line after reviewing, with your initials serving as your consent and understanding of each portion contained in this voluntary agreement.

I understand this policy is in effect for anyone over the age of sixteen (16): **https://www.peoples-law.org/youth-health-law**

Initial: ___________

I understand for any individual classified as being a minor, (less than 16 years old) a guardian must consent to the Urine Drug Screen and proposed treatments.

Initial: ___________

I understand if I have commercial insurance or if I am a self-pay patient ***I will be charged twenty-five ($25.00) for each Urine Drug Screen due at the time of service. If I do not pay at the time of service my appointment will need to be rescheduled without obtaining a refill***. Lifespan Behavioral Health Services PC will not be billing your insurance for this service.

Initial: ___________

I understand if I have insurance through Medicare or Medicaid, I will not be charged for my Urine Drug Screen and authorize Lifespan Behavioral Health Services PC to bill and collect payment from Medicaid and Medicare for these services rendered.

Initial: ___________

I understand that I can submit a receipt of payment on my own to my individual insurance carrier for reimbursement and that Lifespan Behavioral Health Services PC will provide a receipt for submission if requested.

Initial: ___________

I will come in for a urine drug test and counting of my pills within 24 hours of being called. I understand that it is my responsibility to provide correct and current contact information to the office staff. I further understand that any urine drug test not completed by me within the parameters set by my provider, will be considered a failure.

Initial: ___________

I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

Initial: ___________

I will participate in all other types of treatment that I am asked to participate in.

Initial: ___________

I will keep my medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

Initial: ___________

I will take my medication as instructed by my provider and will not change the way I take it without my providers consent.

Initial: ___________

I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

Initial: ___________

I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

Initial: ___________

I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

Initial: ___________

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

Initial: ___________

I will sign a release form to let the doctor speak to all other doctors or providers that I see. Below is a list of all my providers and I will fill out Releases of Information for each provider. If it is found that there are other providers not accounted for my treatment will be stopped.

Initial: ___________

I will tell the provider all other medicines that I take and let him/her know right away if I have a prescription for a new medicine.

Initial: ___________

I will use only one pharmacy to get all on my medications filled (and am responsible for updating this office if the pharmacy changes):

Initial: ___________

My Pharmacy name/phone#: ____

I will not get any opioid pain medicines (to include but not exhaustive - Suboxone, Zub-Solv, Bunavail and Subutex) or any medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Adderall) without telling a member of the treatment team **before I fill that prescription**. It is up to me to ask the provider if the medication being prescribed falls into any or all of the above categories. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends. I understand that if I do, my treatment may be stopped.

Initial: ___________

I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

Initial: ___________

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Initial: ___________

Privacy

While I am taking this medicine, my provider may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Initial: ___________

Termination of Agreement:

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

Initial: ___________

I have talked about this agreement with my health care provider, been allowed the opportunity to ask questions and have had those questions answered and I understand the above rules and my individual requirements.

Initial: ___________

If I use medical marijuana a copy my Maryland Marijuana Card will be provided at the time of the urine drug screen. If a card is not provided and my urine drug screen is positive for marijuana (THC) controlled substances will not be prescribed and/or left at the discretion of your clinician to prescribe to you based upon your individual circumstances.

Initial:_____________

Provider Responsibilities

As your provider I agree to perform regular checks to see how well the medicine is working.

This document has been reviewed with and signed by the provider and patient. (A signed copy stamped with patient's insurance card and if applicable Maryland Marijuana Card should be scanned to the medical record and a copy given to the patient.)

Client Signature: ______________________ Client Name: _____________________ Date: _________________

Guardian Signature: ____________________ Guardian Name: _____________________ Date: _________________

Providers Signature: ____________________ Provider's Name: _____________________ Date: _________________