CONTROLLED SUBSTANCE POLICY

As part of your treatment, your physician may order medications for you. Many of these medications can have serious side effects if they are not managed properly. You will be made aware of any side effects from medications that we have prescribed for you. Please read the following agreement **CAREFULLY** and ask your doctor/nurse if you have any questions:

1. I agree to follow exact dosing instructions prescribed by my physician.
2. I agree to keep all appointments required by my physician. If I miss an appointment, I understand that a follow up must be made before any prescriptions will be refilled or changed.
3. I agree to maintain all prescriptions at the same pharmacy, unless reasonable circumstances occur.
4. Refill requests are to be made during office hours only. Mon-Thurs 9:00 am to 4:00pm. Fridays 9:00 a.m. to 11:00 a.m.
5. Refill requests must be made in **ADVANCE** (7 days). If my physician is out of the office, I understand that my prescription **will not** be filled until they return.
6. **NO CONTROLLED SUBSTANCES WILL BE FILLED DURING EVENINGS, WEEKENDS OR HOLIDAYS!**
7. If a prescription is lost or stolen, it will **NOT BE REFILLED**. It is your responsibility to keep track of your medications.
8. I understand that any misuse of my medications will be reported to the appropriate authorities and I can be terminated from the practice.

I agree that I have read and fully understand this controlled substance contract. I will ask my physician if I have any questions regarding the potential risk of dependency, addiction and side effects of the medications given to me. I do understand that a breach of this contract will result in my termination from Valdosta Psychiatric Associates, LLC.

Patient Name: _____ D.O.B.: _____

_____ Date: _____

Patient Signature

Physician: _____

Pharmacy Name: _____ Phone #: _____