MACS

Maryland Addiction Consultation Service

Controlled Substances Agreement

This agreement is made between you (the patient) and your treatment provider to ensure the safe and effective use of controlled substances. The purpose of this agreement is to establish clear expectations and responsibilities regarding the use of controlled medications that are being prescribed to you.

Specifically, we want you to know that the use of _____ *(insert names of medications)* **could cause physical dependence, carries a risk of misuse, and may lead to substance use disorder. These medication(s) can also have potentially dangerous side effects, especially if combined with alcohol other controlled substances. These medication(s) are an important part of your treatment plan for _____** *(insert name of conditions)* **but work best when combined with other therapies as recommended.**

Patient Responsibilities

As a patient, I agree to the following:

- I will take medications as prescribed and will not change the dosage or frequency without approval.
- I will only use one pharmacy to get my medicine.
- I will store my medication in a secure place, out of reach of others for whom it is not prescribed.
- I will not share, sell, or trade my medications with anyone.
- I will inform my provider of all other medications I am taking including new prescriptions.
- I will keep all scheduled appointments and cooperate with treatment plans including additional treatments (counseling, physical therapy, specialist visits, etc).
- I will complete required drug screenings (urine, saliva, or blood tests) when requested
- I will inform my provider of any side effects or issues related to the medications.
- I will inform my provider if I am or become pregnant which could require modifications to my medications.
- If I do not fulfill the above responsibilities, or if my provider decides that this medicine is hurting me more than helping me, this medicine may be stopped in a safe way.
- I understand that alcohol and these medications can be dangerous together, and I will use caution with driving and operating machinery

Provider Responsibilities

As your treatment provider, I agree to perform regular checks to see how well the medicine is working. I also agree to provide education about the medications prescribed and their potential risks.

Terms of Agreement

- Breaking this agreement may result in modification or discontinuation of controlled substance prescriptions.
- Requests for early refills of medication may not be granted.
- The provider may terminate this agreement if there are concerns about your safety, diversion of medications, or repeated lost or stolen medication.

By signing this agreement, I acknowledge that I have read, understand, and agree to the terms outlined above.

Patient Name: _____

Signature: _____ **Date**: _____

This agreement may be updated as needed to reflect changes in your care or new safety guidelines.