

## CONTROLLED SUBSTANCES (BENZODIAZEPINE) TREATMENT AGREEMENT

**The purpose of this agreement is to protect your access to controlled medication and to protect our ability to prescribe it for you.**

I understand that controlled substance medications are regulated by the government because they have the potential for misuse. Therefore, my prescription will be written for one month's supply at a time.

I agree to take my medication as prescribed.

I acknowledge that I am responsible for protecting my written prescription and my medications. I understand that if my medication is lost, stolen or used up sooner than prescribed, it will likely not be replaced.

I recognize that long-term use (more than two months) of this medication is not approved and may lead to tolerance, dependence and addiction issues. Because of these risks, prescriptions will not be renewed earlier than 30 days from the previous prescription date.

I understand that it possible for me to become physically dependent on the medication, which means if I stop the medication suddenly, I may develop serious or life-threatening withdrawal symptoms.

I agree to allow my prescriber to order any testing needed to make sure I am using my medications correctly, including not abusing illicit substances. I understand that I may be tested at any time and if I do not comply with the request within 24 hours, my medication may be discontinued.

I acknowledge that it is both illegal and potentially very dangerous to share or sell prescription medications to another person.

I understand that my mental status will be assessed and monitored on a regular basis to see how my treatment plan is working. Renewals of prescriptions, if indicated, are contingent upon keeping routine therapy and prescriber appointments.

If requested, I agree to engage in therapy to learn and use behavioral skills to cope with symptoms and plan to reduce the dosage of these medications in order to minimize risk of tolerance/dependence.

I will not request or seek out benzodiazepine medications from anyone else, including other clinicians, emergency departments, dentists, and so forth. I understand it my responsibility to know if I am taking this type of medication.

I will use only one pharmacy for all of my controlled substance medications and give my provider and his/her staff full permission to communicate with the pharmacist about my care and medication.

I agree to notify all providers involved in my care of my current medication regimen, including any benzodiazepines.

**If I violate any of the conditions of this agreement, my controlled substance medications may be gradually tapered or stopped.**

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Client

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Provider

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Date