

MOSAIC MIND PSYCHIATRY
Controlled Medication Agreement

This is a treatment agreement between healthcare provider with MOSAIC MIND PSYCHIATRY and a patient who is or may be prescribed a controlled substance. This document is to ensure patient is aware that certain prescribed controlled substances—including, but not limited to, narcotic pain medications, stimulants, benzodiazepines, and barbiturates—carry a risk of abuse, may be misused by others, and can lead to addiction or relapse. The patient understands the importance of following strict guidelines for their use and agree to comply with the terms and procedures outlined in this Agreement. The patient acknowledges that adherence to these rules is a condition for the physician's willingness to prescribe or continue prescribing controlled substances for treatment.

As a patient of **MOSAIC MIND PSYCHIATRY** I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time for all of my scheduled appointments; to adhere to the payment policy outlined by this office. I agree to call at least 24-hours in advance if I must reschedule my appointment. I understand that a last minute reschedule (less than 24 hours notice) counts against me as a "No Show" appointment. I understand that I may be discharged from the office after three "No-Shows" in one year or two consecutive "No-Shows".
2. I agree to conduct myself in a courteous manner in the doctor's office. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
3. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
4. I agree to only use one pharmacy for my controlled medications. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
5. I agree that my prescription can only be given to me at my regular office visit. **A missed visit may result in not being able to get my prescription until next visit.**
6. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost/stolen medication will not be replaced for any reason. I agree not to obtain other controlled mental health medications from any other medical providers, pharmacies, or other sources.
8. I understand that mixing controlled medications or alcohol can be dangerous. I recognize that several deaths have occurred among persons mixing benzodiazepine and opioid pain medications (especially if taken outside the care of a medical provider or in higher than recommended doses). I agree to inform my provider if I am going to a pain management office.
9. I agree to take the medication as my medical provider has instructed and not to alter the way I take the medication.
10. I recognize that my mental health is important and medication management alone is not sufficient. If required by my provider, I agree to participate in counseling with a counselor

monthly. Failure to comply with counseling appointments will result in my provider's appointment being cancelled or not receiving my medications until I have seen the counselor.

11. I agree to abstain from alcohol in excess or over recommended allowances, marijuana, and other illegal substances. I understand if I fail three urine screens for alcohol or illegal substances, that is grounds for dismissal from the office.
12. I agree that my provider has the right to call me in for a random pill count, urine screen, and/or administer a breathalyzer test. I understand that I will be subject to a urine drug screen on a regular basis, and I agree to their associated fees. If necessary, I understand that I may be subjected to a monitored urine drug screen. If I do not provide a urine sample, it will count as a failed drug screen. A failed drug screen includes testing positively for non-prescribed medications or the absence of prescribed medications in your system.
13. I understand that violations of this contract may be grounds for termination of treatment.
14. I understand that it is my responsibility to disclose any other controlled prescriptions from other prescribers. PA PDMP will be checked routinely.
15. I understand controlled substances can only be sent to pharmacies within the state of Pennsylvania.
16. Appointment and urine drug screen frequency is up to provider and typically requested every 3 months for each.

Patients Name (printed) _____

Signature of patient or legal guardian _____

Date Signed _____