Patient Controlled Substance Agreement Informed Consent Form

The following agreement relates to my use of controlled substance for Psychiatric Care prescribed by a Nurse Practitioner of Kairos Counseling Services, LLC. I recognize that there are policies regarding the use of controlled substances that are followed by the staff. I will be provided controlled substances while actively participating in this program only if I adhere to the following regulations: (please initial)

_____ I will use the substances only within the parameters given by my treating Nurse Practitioner. In addition, I will not increase the dose or frequency unless instructed by my Nurse Practitioner.

_____ I will not receive replacement medications or prescriptions for "lost" or "stolen" medications.

_____ I will receive controlled substances pertaining to mental health conditions only from my treating Nurse Practitioner. If it is learned that I am receiving controlled substances outside of Kairos Counseling Services LLC, my treatment will be discontinued, and I may be discharged from the practice.

_____ I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my new prescription runs out. I will be responsible for "stretching out or self-extension" of my medications if my new prescription is dated for a weekend, holiday or any other date when I cannot fill the prescription. Prescriptions will not be rewritten for a new date unless determined by the direction of my Nurse Practitioner.

_____ Refills of medications will not be given over the telephone. You are to contact your pharmacy to request a refill of medications.

_____ In general, a maximum of thirty days' supply of medicine will be prescribed at any one time. Refills written on original RX's will be by Nurse Practitioner discretion only.

_____If it appears to the Nurse Practitioner that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as prescribed by the Nurse Practitioner. I will not hold any member of Kairos Counseling Services, LLC liable for any difficulty or unfounded effect caused by discontinuation of controlled substances provided that I receive 15 days' notice of termination.

_____ I agree to submit to urine and/or blood screens to detect the use of non-prescribed or prescribed medications at the request of my Nurse Practitioner. I agree to the Prescription Monitoring review as outlined by the Commonwealth of Virginia.

_____ I agree to medication counts as needed within a 48-hour notice at the request of my Physician/Nurse Practitioner

_____ I recognize that my psychiatric care represents a complex problem which may benefit from behavioral medicine strategies and psychotherapy. I also recognize my active participation in the management of my care is extremely important. I agree to actively participate in all aspects of the behavior psychiatric management program in order to secure increased function and improvement in learning how to cope with my condition.

Parent/Patient Signature _____Date: _____

Physician Signature _____ Date: _____

Witness, Family Member or Significant Other Signature:

_____ Date: _____