Psychiatry of SA

I understand that I am responsible for each statement, and I will initial each term I agree to and sign.

_____ 1. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my provider will treat me based on this Agreement.

_____ 2. I understand that ***if I break this Agreement, my provider will stop prescribing these controlled medicines.*** Some cases require tapering off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms, Also, a substance dependency treatment program may be recommended.

_____ 3. I ***will not use any illegal substances including heroin, cocaine, etc.*** I will not share, sell or trade my medication with anyone. I will report any and all use of cannabis.

_____ 4. I will not attempt to obtain any controlled medicines, including opiate pain medicines, controlled stimulates, or anti- anxiety medicines from any other doctor. In the event that I develop a serious acute medical condition that another healthcare provider, such as an Emergency Department doctor determines requires adjustments to my controlled substance use, I will notify my provider immediately of the changes.

_____ 5. I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

_____ 6. I agree that refills of my prescriptions will be made only at the time of an office visit or during regular office hours.

_____ 7. I ***will not adjust the dose or amount of controlled substances I take***, without first discussing and obtaining approval from my provider.

_____ 8. I will only request refills of my controlled medication during weekday business hours 8:00 am – 5:00 pm.

_____ 9. ***Due to pharmacy shortages is not Psychiatry of San Antonio's responsibility.***

_____ 10. I agree that ***I will use my medicine at a rate no greater than the prescribed rate*** and that use of my medicine at a greater rate will result in my being without medication for a period of time and/or my provider will discontinue prescribing the medicines.

_____ 11. I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or other diversion of my controlled medicine. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ 12. I agree that ***I will submit to a blood or urine toxicology screening at least three times yearly*** as requested by my provider to determine my compliance with my program of controlled medicine use. I understand that my provider ***may choose to do toxicology testing more frequently.***

_______ ***13.*** **Prior** to appointment Call Pharmacy and make sure your medication is in stock and that we are using the pharmacy that is on file.

_______ 14. **Changing Pharmacy Fee is *$25.00.* Medication send out is *24-72 hours* and if you change pharmacies the process starts over for your medication.**

Medication(s):____

By signing below, I have read and agreed to each statement and the terms in this contract with Psychiatry of San Antonio.

_______________________________________   _______________________

Patient Name: (First) (Last)   **Patient Date of Birth: (MM/DD/YYYY)**

_______________________________________   _______________________

Patient/Legal Representative Signature   **Date Signed**

_______________________________   **Dr. Tracey Cawthorn, MD**

Provider Signature   **Prescriber Signature**

Psychiatry of San Antonio - 1009 NW Loop 410, Castle Hills, Tx, 78213

Phone: 210.742.6551 | Fax: 210.714.0744 | Office@psychofsa.com

Scanned with CamScanner