
***Psychotropic Medications ("Psych Med"): Patient Agreement

Psychotropic Medications: Patient Agreement

This agreement is designed to ensure safe, responsible, and effective use of prescribed psychotropic medications. Please read each statement carefully and mark "I acknowledge" to show that you understand and agree to each item.

By signing below, you acknowledge and agree to the following:

1. Medication Use

• I will take my medications only as prescribed and will not alter the dosage, frequency, or discontinue use without prior approval from my provider. • I will not share, sell, misuse, or otherwise distribute my medications. • I will promptly notify my prescriber if I take medications that are not prescribed for me, including amphetamines, cocaine, opioids, benzodiazepines, and cannabis products taken through any means of intake or insertion or any modality of usage or introducing into the body. • I will keep the medicine safe, secure, and out of the reach of children. • I will take my medication as instructed and not change the way I take it on my own. *

☐ I acknowledge

2. Appointments & Follow-Up

• I understand that regular follow-up appointments are required for safe medication management. • I may be required to appear in person for appointments at the discretion of my provider. • I acknowledge that failure to attend scheduled appointments, or repeated cancellations/rescheduling, may result in discontinuation of medication management. *

☐ I acknowledge

3. Monitoring & Compliance *

• I understand that routine or random drug screens may be required at any time to ensure medication safety and compliance. • I agree to bring my medications to EACH appointment unless instructed by my provider not to do so. • I will notify my provider immediately of any side effects, new medications, or changes in my health. • (For women only) If I am capable of becoming pregnant - I recognize there may be serious potential risks of taking psychotropic medications on the fetus. I will discuss my plans to get pregnant with my provider and notify my provider promptly if I become pregnant. *

☐ I acknowledge

4. Prescriptions & Refills *

• Prescriptions and refills will only be issued during scheduled appointments and with sufficient advance notice. • Lost, stolen, or damaged prescriptions/medications may not be replaced unless reasonable explanation is given and it's upon the discretion of the provider. We do urge you to get a police report for stolen controlled substances. *

☐ I acknowledge

5. Communication & Conduct *

• I agree to provide accurate and updated personal, medical, and pharmacy information at all times. • I will communicate respectfully and appropriately with all clinic staff and providers. • I will not accept or obtain prescriptions for benzodiazepines (Klonopin, Xanax, Ativan, Valium, etc.) or stimulants (Ritalin, Adderall, etc.) from other providers outside the Center for Integrative Psychiatry. If I am prescribed pain medication that contains opioids (such as hydrocodone, morphine, tramadol, etc), I will promptly notify my provider of the prescription. • I agree to only use one single prescriber and one single pharmacy for obtaining my controlled medication and will inform my sole prescriber of an alternative pharmacy in the case of prescribed medications being out of stock. I will not seek out multiple prescribers nor utilize multiple differing pharmacies. *

☐ I acknowledge

6. Acknowledgment of Consequences *

- I understand that failure to comply with this agreement may result in modification or termination of my medication treatment plan. *
- ☐ I acknowledge

By signing below, you acknowledge and agree to all the above statements:

PATIENT (OR GUARDIAN)

SIGNATURE *

Date signed *
