Balance Behavioral Health PLLC
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Patient Agreement for Controlled Substances Therapy

1. I _____ agree that Tim Walsh, PMHNP-BC will be the ONLY clinician prescribing controlled substances that pertain to psychiatric care (examples of controlled substances prescribed by a psychiatric nurse practitioner would include anxiolytics, sedative-hypnotics and stimulants), and that I will obtain all of my prescriptions for this medication at ONE pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my clinician as soon as possible.

2. I understand the importance of taking the medication at the dose and frequency prescribed. I will take my medication as instructed and not change the way I take it without first talking to my clinician or other members of the treatment team.

3. My clinician reserves the right to require urine testing as a matter of routine monitoring.

4. I will attend all reasonable appointments, treatments, and consultations as requested. I will make sure I have an appointment for refills. Prescriptions will only be filled during scheduled office visits. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

5. I understand that I should check with my clinician or pharmacist before taking other medications including over-the-counter and herbal supplements.

6. I agree not to give or sell my prescribed medication to any other person. I acknowledge that my clinician is not obligated to replace ANY medication shortfall and my treatment could be stopped. I will not receive replacement medications or prescriptions for “lost” or “stolen” medications.

7. I consent to open communication between my clinician and any other healthcare professionals involved in my care, such as pharmacists, other doctors and or emergency departments etc.

8. I understand that if I break this agreement, my clinician reserves the right to stop treatment. If it is learned that I am receiving controlled substances outside of Balance Behavioral Health, PLLC my treatment will be discontinued, and I may be discharged from the practice.

9. 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 Balance Behavioral Health, PLLC liable for any difficulty or unfounded effect caused by discontinuation of controlled substances provided I receive 15 days’ notice of termination.

10. As a general rule, controlled substances are not prescribed at a patient’s first initial appointment. Exceptions to this are at the discretion of the provider.

11. 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.

_____	_____	_____
(Signature of Patient)	**(Signature of Clinician)**	**(Date)**