Ziks Health Services
3000 Custer rd. Suite 270
Plano TX 75075
972-972-4850

Controlled Substance Agreement

I UNDERSTAND AND AGREE TO THE FOLLOWING: (please initial each after reading)

_____ 1. This Controlled Substance Agreement relates to my use of any and all medication(s) to manage my condition as prescribed by my provider, Ziks Health Services providers.

_____ 2. All medication(s) and prescriptions for the treatment of my condition will be obtained from this provider only.

_____ 3. Medication(s) for the management of my condition will be provided by my provider so long as I follow the terms and conditions specified in this agreement. Failure to comply with any of the terms and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my provider's care and treatment. Discharge from my provider's care and treatment may be immediate for any criminal behavior.

_____ 4. All medication(zs) prescribed by my provider and other medication(s) prescribed by other providers must be obtained at only one (1) pharmacy. I will provide my pharmacist with a copy of this agreement at the request of my provider.

_____ 5. I will use the medication(s) exactly as directed by my provider.

_____ 6. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued by my provider.

_____ 7. Use of illegal substances, alcohol, and other mood-altering drugs (including cannabis) can counteract any potential benefits of these medications and may lead to dangerous side effects. I agree to submit to urine and / or blood screens to detect the use or non-use of non-prescribed and prescribed medication(s) and / or substance(s) at any time and without prior warning. Any evidence of use of illegal substances and/or THC will lead to discontinuation of the medication(s).

_____ 8. My provider may at any time choose to discontinue the medication(s) for the treatment of my condition.

_____ 9. I will disclose to my provider all other medication(s) that I take at any time, prescribed by any provider other than this provider. I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.

_____ 10. I will not share, sell, or otherwise permit others, including my family and friends, to have access to my medication(s).

_____ 11. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. Lost or stolen medication(s) and / or prescriptions may not be replaced.

_____ 12. I agree not to obtain or seek to obtain any other psychiatric medication(s) from any other source (including Emergency Department, "urgent care clinic," etc.) without first contacting my provider. Information that I have been receiving other medication(s) prescribed by other doctors that has not been approved by my provider may lead to a discontinuation of the medication(s) and treatment.

_____ 13. I understand that the State of Texas tracks information provided by pharmacies regarding all controlled substance prescriptions. My provider will access this data during the course of my treatment regardless of whether I am currently receiving a prescription for a controlled substance.

_____ 14. I understand that refills will NOT be ordered before the scheduled refill date even if my medication(s) runs out. When traveling, arrangements may be made in advance of planned departure date. Refills will not be provided outside of a regularly scheduled appointment.

_____ 15. If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my provider may try alternative medication(s) or may taper me off all medication(s). I will not hold my provider liable for problems caused by the discontinuance of the medication(s).

_____ 16. I recognize that my condition represents a complex problem which may benefit from other therapies (i.e., talk therapy, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommend by my provider to achieve increased function and improved quality of life.

_____ 17.I hereby give my provider permission to discuss all diagnostic and treatment details with my other provider(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).

_____ 18. I must keep all follow-up appointments as recommended by my provider or my treatment and / or medication(s) may be discontinued.

By signing below,I hereby authorize and give my consent to administer or prescribe the prescription(s) for controlled substance(s) (medication(s)) as part of therapy or treatment for my condition.

All questions and concerns have been addressed.
(If patient is 13 years of age or younger, this agreement is put in force following signature by a parent/guardian.)

Patient's printed name_____

Patient's signature_____Date_____

Provider's signature_____Date_____