Mindworks Wellness

1139 E. Stuart St, Suite 4-101

Fort Collins, CO 80525

(970)658-0535

Agreement for Controlled Substances

I, _____ agree that Elizabeth Walton PMHNP will be the only provider prescribing my controlled medication _____. I will obtain all my prescriptions for this medication at one pharmacy.

I understand the importance of taking the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose or frequency without first discussing and obtaining approval from my provider.

My provider may require random urine testing or pill counts as a matter of routine monitoring. I agree to pay all costs incurred as a result of these requirements.

I will attend on time all scheduled appointments as required by my provider.

I understand that I should always check with my provider before taking other medications including over-the-counter and herbal products.

I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my medication if their knowledge could result in theft, illegal sales or use, or other illicit activities. I agree not to give or sell my prescribed medication to any other person.

I acknowledge that my provider will not refill early for any reason including lost or stolen meds. If I intend on being out of town during a refill period, it is my responsibility to schedule an appointment with my provider to discuss and arrange for refills during that time. I understand that expected prescription refill dates will be used to promote optimal use of this medication.

I consent to open communication between my provider and any other health care professionals.

I agree that I will not take this medication with any benzodiazepines or hypnotic drugs. This includes drugs such as Lyrica or clonazepam.

I understand that if I break this agreement, my provider reserves the right to stop prescribing stimulant medication for me.

Date: _____

Signature: _____