ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE:1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

Controlled Substance(s) / Medication Refill Policy

Controlled substance medications (i.e. benzodiazepines, opioids and amphetamines) are very useful, but have a high potential for misuse. Controlled substances are closely controlled by local, state and federal authorities. As a patient of Orlando Psychiatric Associates, you agree and understand the following **(initial each section)**.

I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if misused. I understand that this medication will not be replaced regardless of the circumstances.
Initial_____

Refills of controlled substance medications:

a. Will be made only during regular office hours Mon-Fri, in person, once a month and during a scheduled office visit. Refills will not be made at night, weekends or on holidays.

b. Will not be made for lost, misplaced or misused medications. The security, management and proper usage of controlled medications are the sole responsibility of the patient / and or guardian.
Initial_____

I agree to comply with urine drug testing and pill counts at every appointment, thereby documenting the proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.
Initial_____

I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities. Initial_____

I understand that if I violate this policy due to non-compliance of medical direction resulting in misuse or abuse of prescribed medications or illicit drugs, I may be subject to dismissal from care at Orlando Psychiatric Associates.
Initial_____

I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in the office. Initial_____

I agree to not sell, share, give away or divert my medications into any form of misuse or abuse. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal. Initial_____

I agree to not obtain medication from any doctors, pharmacies or other sources without informing my treating clinician. Initial_____

I agree to take my medication as my clinician has instructed and not to alter the way I take my medications without first consulting my doctor. Initial_____

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I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine and other addictive substances. Initial_____

I agree to fill all of my controlled medication at an in-state (Florida) pharmacy. I will list my pharmacy of choice below and understand that I must use this pharmacy. If at any time, I choose to change my pharmacy, I will notify OPA and complete this information again. Initial_____

I understand that there will be NO PRESCRIPTIONS FOR PAIN MEDICATIONS. Initial_____

I understand that medical records (from other prescribers) must be transferred to OPA before any controlled medications will be prescribed. Initial_____

Pharmacy Name_____ Pharmacy phone_____

I understand that OPA utilizes the State of Florida Drug Monitoring Database and will monitor my prescription history via this source. Initial_____

I have been fully informed of the above treatment agreements and have a full understanding of my duties as a patient of Orlando Psychiatric Associates in regard to the controlled substances and any subsequent refills.

Patient Signature_____Date_____

Physician Signature_____Date_____