HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

PRESCRIPTION MEDICATION OF A CONTROLLED SUBSTANCE

Patient's Full Name:	Date of Birth:
If the patient is less than 18 years of age and not legally emancipated; or if the patient has been adjudicated mentally incompetent, please print Full Name of Legal Guardian/Representative:	
CS Rx & Strength	Prescriber's Name & Credentials:
ICD-10:	Lic. & DEA #:

As a mental and behavioral health care provider, Human Behavior Institute is required by Nevada law to obtain the patient's and/or legal guardian's written informed consent prior to prescribing a Controlled Substance (CS). In compliance with AB 474, please ***read carefully*** *and initial each paragraph.* ***If you have any questions on any of the following statements, please ask your provider*** *before signing to indicate your full understanding and acknowledgement of all the terms specified in this prescription medication agreement.*

I have discussed my treatment plan with my provider, and have a good understanding of my overall treatment goals as tailored to my medical condition. Initial

As part of my treatment plan, I may be prescribed medications including a controlled substance that can be used to treat anxiety, attention-deficit hyper-activity disorder, sleep disorder, depression, or other conditions that I'm diagnosed with. Initial

I understand that these medications have known risks and side-effects, and can be harmful if taken without medical supervision and/or against prescribed instructions. Side effects may include but are not limited to:

- Constipation
- Itching
- Irregular heart rate
- Depression
- Suicidal thoughts
- Nausea/vomiting
- Low blood pressure
- Inability to sleep
- Impotence
- Addiction or overdose
- Excessive drowsiness or sleepiness
- Shortness of breath
- Impaired judgment and/or reasoning
- Tolerance to medication
- Physical or psychological dependence

Initial

I understand that it may be dangerous to drive a vehicle or operate a machinery while taking these medications. Initial

I understand that not every possible risk and benefit is listed in this form, therefore, I will inform my provider immediately if I experience any other side-effects that develop during the course of my treatment. Initial

I have discussed with my provider the potential risks and benefits of these medications, and other treatments, including their risks and benefits. If the medication is an opioid, I understand that I can get the medication to counteract its effect without a prescription. Initial

For Female Patients in Child Bearing Age (between 15 and 45 years): Are you currently pregnant? ☐ Yes ☐ No

I understand that there are unknown risks and side-effects of prescribed medications to an unborn child. Chronic exposure to controlled substances during pregnancy, can lead to, without limitation, the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome. If I become pregnant, I will inform my physician immediately of all medications I am taking. Initial

For Minors:

I understand the risks that my child may abuse or misuse the controlled substance or divert the controlled substance for use by another person. I have been informed of the ways to detect such abuse, misuse or diversion. Initial

I understand that all medications must be properly stored and not easily accessible for children. In addition, I have been informed of the proper disposal of these medications, and how my provider will address my request for refills. Initial

I understand that Nevada law requires my provider to obtain my pharmacy utilization report from the computerized program established by the Board and the Investigation Division before initiating a prescription for a controlled substance. Additionally, it requires my provider to obtain such a report at least every 90 days for the duration of the prescription; and to make certain determinations based on the report. Initial

I understand that prescriptions and refills will only be provided during scheduled office visits, and it is my responsibility to make sure that I schedule and attend my appointments. I further understand that my medications are my responsibility, and if lost or stolen, my medication may not be replaced until my next scheduled appointment, at the judgement of my prescriber. Initial

I will inform my provider immediately about:

- any other controlled substance prescribed to me or taken by me
- drinking alcohol, using marijuana products or any other cannabinoid compound, while I am taking my medications
- receiving treatment for any side effects or complications relating to the use of the controlled substance, including whether I have experienced an overdose
- all medications I've been prescribed by other practitioners, including those from other states

Initial

I authorize my provider to monitor my drug use, when my provider deems it necessary, including, without limitations:

- Urine, hair, and blood testing
- Bringing my medications to the prescriber's office where the number of pills may be counted

Initial

I agree to use my medications only as prescribed, and I will not share my medications with any other person. Initial

I understand that part of my treatment goals during my therapy may include minimizing or even discontinuing the use of controlled substances. I understand that my therapist may recommend minimizing and discontinuation of a controlled substance for various reasons, including:

- the presence or development of adverse side-effects
- any signs of misuse, abuse, diversion, or addiction
- attempts to obtain CS medications from other providers
- use of illegal drugs or other medications that may interact with the controlled substance
- refusal to comply with my treatment plan
- any reason that my provider may deem in my best interest to reduce or discontinue the controlled substance

Initial

I understand that medication management is only a portion of my treatment. I understand that my treatment plan may include psychotherapy, psychosocial services, physical exercise, family or social support, education, and healthy living in order to improve my condition. Initial

I have read and hereby acknowledge each of the statements above, and had the opportunity to have all my questions answered. I understand that if I violate any part of this prescription medication agreement, I may be denied prescription for controlled substances and may be discharged from Human Behavior Institute. I further acknowledge that I'm required by law to review and execute a prescription medication agreement with my provider at least once every 365 days as long as I'm receiving prescriptions for controlled substances. By signing below, I agree to abide by all the above terms and conditions as part of my treatment at Human Behavior Institute.

Patient's Signature	Print Patient's Full Name	Date
Parent's/Legal Guardian's Signature	Print Parent's/Legal Guardian's Full Name	Date