Enclosed you will find our new client information packet. Please complete all forms and return them to Serenity Now. Once we receive your completed packet with a copy of your insurance card, your information will be reviewed by our Clinical team to determine if we can appropriately serve your needs. Serenity Now is an independent psychiatric and counseling clinic which provides specialized services. When our ongoing clients are interested in psychiatric medication management, we work on a team philosophy in which clients receiving medications are also actively engaged in therapy with our staff at Serenity Now. At this time we are unable to see children under the age of 12 for medication management.

**FIRST APPOINTMENT:** Coming in for treatment for the first time to a new location can be intimidating for some. You will be meeting with one of our therapists on your first appointment to complete your initial evaluation. If appropriate, the therapist will make arrangements for you to be scheduled with one of our prescribers for medications at a later date. **You will not be prescribed medication on your initial evaluation at Serenity Now.**

If the client is a minor (under the age of 18) the legal guardian (parent, case worker or state appointed guardian) **MUST BE PRESENT FOR THE INITIAL APPOINTMENT** and at every medication appointment with Dr. Eckard or Carrie Long, PMHNP. If there is a custody arrangement, make sure to bring a copy of the custody papers.

If you have any mental health records, school records or psychological testing within the last five years, please obtain a copy and have them sent to our office. In order to provide the best mental health services it is crucial to obtain as much background information as possible. Please complete any needed Releases of Information so we may contact your referring resource.

**ATTENDANCE:** We have a strict policy in place on attendance. It is the policy of Serenity Now that failure to attend a scheduled appointment or failure to cancel a scheduled appointment more than 24 hours in advance, may result in a $25 fee. This fee will need to be paid prior to your next appointment. Three no-shows or late cancellations within a 6 month period will result in termination of services. If you miss your initial appointment we will not reschedule.

Thank you for considering us for your mental health needs.

Serenity Now Psychiatric and Counseling Services
Serenity Now Patient Demographic Sheet

Name: ________________ Date of Birth: ________________
First Middle Last

Address: ________________________________________________

City/State/Zip: ____________________________ Social Security Number: ____________________________

Sex: Male / Female

Status: Single / Married / Widowed / Divorced

Guardian Name: ____________________________ Custody: Joint / Mother / Father / Other ________________

Email address: ____________________________

Is this visit covered by your Employee Assistance Program (EAP): Y / N Authorization Number: ____________________________

Emergency Contact

Name: ____________________________ Phone: ____________________________

Relationship: ____________________________

Primary Insurance

Company: ____________________________ Policy Number: ____________________________

Policy Holder Name: ____________________________ Policy Holder Date of Birth: ____________________________

Policy Holder Address: ____________________________ Policy Holder SS#: ____________________________

City/State/Zip: ____________________________ Relationship to Patient: ____________________________

Secondary Insurance

Company: ____________________________ Policy Number: ____________________________

Policy Holder Name: ____________________________ Policy Holder Date of Birth: ____________________________

Policy Holder Address: ____________________________ Policy Holder SS#: ____________________________

City/State/Zip: ____________________________ Relationship to Patient: ____________________________

Financial Responsibility

Name: ____________________________ Relationship: ___________ Date of Birth: ___________

Address: ____________________________ Phone Number: ____________________________

City/State/Zip: ____________________________ Employer: ____________________________

Coordination of Benefits

Primary Care Doctor: ____________________________ Phone Number: ____________________________

I give permission to Serenity Now Psychiatric and Counseling Services to contact my primary care provider to inform them that I am seeking treatment. This information will be limited to the Coordination of Benefits guidelines and will not include personal information disclosed during treatment without a Release of Information signed by myself/guardian/representative.

Signature: ____________________________ Date: ____________________________

Revised 12/2018
CLIENT SELF-ASSESSMENT

The following questions will help us to know you and help in the planning of your care. Please answer all questions to the best of your ability. All information received is confidential.

Name________________________________________ Age______ Date of Birth_/__/____

If Child: Parents' Names: ________________________________
Phone Numbers: ________________________________________
Are parents divorced?: ___________
Who does child live with?: ________________________________

A biological parent or legal guardian must attend the first appointment

Custody status: ________________________________

***We require copies of custody papers before scheduling appointment.***

Who referred you here?_____________________________ Today’s Date__/__/____

Presenting Problem and History of Present Illness:
Please tell us about the events that brought you here today:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

When did the problem / symptoms start?: ______________________________________________________________________________________

Was there anything that happened to bring on the problem or make it worse?: ______________________________________________________________________________________

Have you tried anything to help the problem?: ______________________________________________________________________________________

What have you tried?: ______________________________________________________________________________________

Are you currently in treatment?: ☐ Yes ☐ No With whom? ________________________________

What services are you seeking?:
☐ Individual Therapy ☐ Medication ☐ Family Therapy ☐ Group Therapy
☐ Couples Counseling ( Please be aware that it is a requirement of treatment to be in therapy)
If currently in treatment elsewhere, why are you wanting to seek services with us?:

Please check if you are having problems with any of these:

- ☐ Anger
- ☐ Appetite
- ☐ Concentration
- ☐ Energy
- ☐ Hallucinations
- ☐ Mood
- ☐ Relationships
- ☐ Sleep
- ☐ Thinking
- ☐ Thoughts of hurting Self
- ☐ Thoughts of hurting others

**Past Psychiatric Treatment:**
Have you had counseling for this problem? If yes, when, with whom, and was it helpful?:

Have you taken medication for this problem? If yes, what, when, who prescribed it, and was it helpful?:

**Medical History:**
Illnesses: Please check any of the following that you have, or have had had in the past.

- Respiratory problems: ☐ Asthma ☐ Infectious Disease
- Cardiovascular problems: ☐ Heart Murmur ☐ High Blood Pressure ☐ Low Blood Pressure
- ☐ Anemia ☐ Heart Attack ☐ Bypass Surgery
- Neurological problems: ☐ Seizures ☐ Stroke ☐ Headaches ☐ Blackouts ☐ Head Injury With Loss of Consciousness ☐ Head Injury Without Loss of Consciousness ☐ Neuropathy
- Endocrine problems: ☐ Diabetes ☐ Thyroid
- Gastrointestinal problems: ☐ Reflux ☐ Gastritis/Ulcers ☐ Hepatitis
- Weight change: ☐ Loss ☐ Gain Amount: ________ Length of time: ________
- Musculoskeletal problems: ☐ Arthritis ☐ Fractures ☐ Sprains ☐ Back Pain
- ☐ Physical Limitations ☐ Degenerative Disk
- Skin problems: ☐ Skin Problems ☐ Rash ☐ New Tattoo ☐ Burns ☐ Cuts ☐ Scars
- Sleep problems: ☐ Sleep Apnea ☐ Restless Legs ☐ Snoring ☐ Daytime Fatigue ☐ Insomnia
- ☐ Problem Falling Asleep ☐ Interrupted Sleep

**Hospitalizations:**

**Surgeries:**
Are you experiencing any type of current or chronic pain?: □ Yes □ No

If Yes, Location? ____________________________
How often does it occur?: ____________________ How long does it last?: ________________
What relieves your pain?: _____________________
What makes your pain worse?: __________________

Are you under pain management?: □ Yes □ No
If yes, with whom?: __________________________

Allergies: _________________________________
Reactions: _________________________________

Who are your Primary and/or Treating Doctor(s): _______________________________________

**Current Medications:** (include over the counter medications and nutritional supplements):

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOSAGE</th>
<th>HOW OFTEN</th>
<th>HOW LONG HAVE YOU TAKEN</th>
<th>PRESCRIBED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Language (optional- leave blank if you do not wish to answer)**
My preferred language is: □ English □ Other (please specify) __________________________

SN-CSA/4.18
**Serpenty Now Psychiatric & Counseling Services**  
(A Division of Hoosier Uplands Economic Development Corporation)  
2125 16th St. Bedford IN. 47421  
(812) 275-4053

**Substance Use:**

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Current Use</th>
<th>Past Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Check All That Apply:</td>
<td>Check All That Apply:</td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco/Cigarettes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over-the-Counter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin/Opiates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/Crack</td>
<td></td>
<td></td>
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<tr>
<td>Hallucinogens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Family History:**

Please check if anyone in your family has had any of the following problems:

<table>
<thead>
<tr>
<th>PROBLEMS:</th>
<th>WHO HAD PROBLEM:</th>
<th>PROBLEMS:</th>
<th>WHO HAD PROBLEM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Blood Pressure</td>
<td>Depression</td>
<td>Heart Attack</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Cancer</td>
<td>Mental Illness</td>
<td>Seizure</td>
</tr>
<tr>
<td>Criminal Behavior</td>
<td>Diabetes</td>
<td>Unknown</td>
<td>Stroke</td>
</tr>
<tr>
<td>Depression</td>
<td>Heart Attack</td>
<td>Schizophrenia</td>
<td>Stroke</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Thyroid troubles</td>
<td>Suicide</td>
<td>Other</td>
</tr>
</tbody>
</table>

**Social History:**

I was told I had the following problems in early growth or development:

- [ ] None  [ ] Learning to walk  [ ] Learning to talk  [ ] Major childhood illness  
- [ ] Problems in relationships with others  [ ] Other (please explain)

I have been a victim of violence and/or abuse:

- [ ] None  [ ] Childhood physical abuse  [ ] Childhood sexual abuse  [ ] Childhood emotional abuse  
- [ ] Rape  [ ] Spouse abuse  [ ] Other (please explain)
Education:
☐ I did not finish high school   ☐ I graduated high school   ☐ I have a G.E.D.
☐ I completed some college   ☐ I have a college/graduate degree in________________________

Relationship Status:
I am: ☐ Single ☐ Married ☐ Separated from my spouse ☐ Widowed ☐ Divorced
☐ Currently in a relationship

My sexual orientation is: ☐ Heterosexual ☐ Homosexual ☐ Bisexual
☐ I have concern about my gender identity

I am currently living: ☐ Alone ☐ With spouse ☐ With parents ☐ With children ☐ With partner
☐ With friends/roommates ☐ Other (please specify)______________________________

Race (optional- leave blank if you do not wish to answer)
I am: ☐ white ☐ black or African American ☐ Asian ☐ Native American or Native Alaskan
☐ Native Hawaiian or Pacific Islander ☐ multi-racial

Ethnicity (optional- leave blank if you do not wish to answer)
I am: ☐ not Hispanic/Latino ☐ Hispanic/Latino

Military Status:
☐ None ☐ Veteran ☐ Presently in the military
Number of years/months served:________ Type of discharge:____________
☐ Service connected disability (please explain)____________________________

Employment Status:
I am currently: ☐ Working as a ____________________________
☐ Home maker ☐ Unemployed ☐ Disabled ☐ Student ☐ Retired

I have been fired or asked to resign from my job(s) in the past ☐ Yes ☐ No

Please explain:________________________________________________________

I have/had legal problems in the past or present (criminal or civil) ☐ Yes ☐ No

Please explain:________________________________________________________

I have contact with a Social Agency (Welfare, Social Security, Community Services) to get help for my family or myself: ☐ Yes ☐ No

Please explain:________________________________________________________
I understand the policies listed below and agree to them as a condition of receiving treatment at Serenity Now Psychiatric & Counseling Services:

- Failure to attend a scheduled appointment, or failure to cancel a scheduled appointment more than 24 hours in advance, may result in a $25 fee.
- This fee must be paid prior to the next scheduled appointment.
- Three no-shows or late cancellations within a 6 month period, may result in termination of services.
- In addition, more than 6 cancellations, reschedules, no-shows, and/or late cancellations within a 1 year time period, may result in termination of services.
- A late cancellation or no show with your therapist may also result in the cancellation of all future scheduled appointments at Serenity Now until you are seen by your therapist again.

- As a courtesy, Serenity Now will make reminder calls 1 Day before the scheduled appointment. This call is only a courtesy to our clients. If you do not receive a reminder call, you are still responsible for attending your appointment or rescheduling no later than 24 hours before your appointment to avoid the no show or late cancelation fee.

- If you no show or late cancel an appointment, Serenity Now holds the right to not refill your prescription medication until your next appointment with your medication provider.

__________________________________________
Client Signature

__________________________________________
Date
Client Rights and Responsibilities

As a client of Serenity Now Psychiatric and Counseling Services, you have certain rights while receiving services. It is important that you are knowledgeable and understanding of the services you will receive. This consent acknowledges your voluntary participation and your understanding of these client rights. As treatment begins, you will be asked to participate in the development of your treatment goals.

**Client Rights**

| To receive quality treatment from trained clinical professionals and to be treated with respect. |
| To be free from abuse, neglect, financial or other exploitation, retaliation, or humiliation. |
| To be provided with information about treatment options and their effectiveness |
| To be given information about consent, refusal or expression of choice regarding services, release of information, service providers, and involvement in research projects if applicable. |
| To receive services without regard to your race, color, spiritual belief, gender, sexual orientation, age, language, social and economic standing, or ethnic background. |
| To refuse treatment. |
| To be provided with information concerning side effects of medication that may be prescribed. |
| To look at your medical record, upon approval of your treatment team, and a written request for copies. |
| To your constitutional, statutory, and civil rights, except as denied or limited by a legal proceeding. |
| To be treated in a setting that is most beneficial for your treatment. |
| To tell staff or others if you have a complaint about a staff member or services without having to worry about the complaint affecting your treatment. |
| To be involved in your treatment plan. |
| To privacy during your appointment. |
| To have information about you and the services you receive kept confidential, unless you give us permission or the law states we must share information with others. |
| To obtain the names, qualifications and titles of the professionals providing your care. |
| To be referred to legal entities and private practitioners of your choice at your own expense if requested. |
| To be provided with information and/or referred to self-help and advocacy services. |
| To be assured of adherence to research guidelines and ethics, if applicable. |
| To be assured that alleged infringement of rights will be investigated and resolved in a timely manner. |

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**Client Responsibilities**
Serenity Now Psychiatric & Counseling Services  
(A Division of Hoosier Uplands Economic Development Corporation)  
2125 16th St. Bedford IN. 47421  
(812) 275-4053

- To respectfully treat staff the same way you want them to treat you.  
- To come to your scheduled appointments on time, or call 24 hours before your appointment to cancel and reschedule.  
- To inform the staff of all information that will assist them in helping you.

- To follow your treatment plan and take your medications if they apply to your treatment plan.  
- If you attend group counseling or education sessions, keep any information others in the group share with you confidential.  
- To pay your share of the costs of your treatment and have your insurance billed.

**Client Complaint Process**

If you ever have a concern about your treatment, it is important that the concern be addressed as soon as possible. The following process will assure that your concerns are heard:

- Discuss the concern with your therapist and try to work it out with that person.  
- If you are still unsatisfied, contact the Director of Operations.

- The Director of Operations will hear your concerns and work to find a solution within 7 business days.  
- If you believe your concern has still not been addressed, a member of the Serenity Now leadership team will become involved and will help to reach a satisfactory resolution.

I acknowledge that I have received and reviewed these Client Rights and Responsibilities.

---

Client Signature ___________________________ Date ___________________________
A Division of Hoosier Uplands Economic Development Corporation

1. I, the undersigned, hereby consent to and authorize the administration and performance of all treatment and healthcare operations that, in the judgment of my physician/healthcare provider, may be considered necessary or advisable.

   I further consent to and authorize Serenity Now Psychiatric & Counseling Services, a Division of Hoosier Uplands Economic Development Corporation (hereinafter referred to as Serenity Now) to furnish or release to any insurance company, worker's compensation board, self-insured organization, mutual hospital associations and/or other covered entity and/or their representative, information from or copies of medical records pertaining to me, providing such company or entity is directly concerned in the payment or authorization of cost of my medical treatment.

2. Medicare/Medicaid Claims: Client's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized Medicare benefit be made either to me or on my behalf for any services furnished by Serenity Now including physician services. I authorize any holder of medical and/or other information about me to release Center for Medicare and Medicaid Services and its agent any information needed to determine these benefits or benefits for related services.

3. Assignment of Insurance Benefits: I agree that any benefits of any type arising out of any policy of insurance for me, or any other party liable to me, are hereby assigned to Serenity Now or treating health care provider that renders services for which an assignment if applicable. I understand that I am financially responsible to Serenity Now or treating health care provider for charges not covered by this authorization.

4. Financial Agreement: The undersigned agrees, whether he/she signs as agent or as a client that in consideration of the services to be rendered to the client he/she hereby individually obligates himself/herself to pay the account of Serenity Now and treating health care provider in accordance with the regular rates and terms of said providers. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the rate of eight percent (8%) per annum.

5. Co-pays and Co-insurance: The undersigned understands that all copays are due at the time of service. If the client has co-insurance, where the client is responsible for a percentage of the allowable charges, the undersigned agrees to make a payment at the time of service based on the estimated co-insurance for which the client will be responsible. If this estimate results in overpayment, the account balance will be credited for future visits. A refund will be applied upon request.

6. HIPAA Notice of Privacy Practice: The undersigned hereby acknowledges being advised of the HIPAA Notice of Privacy Practice of Serenity Now and has been offered a written copy of that document. If the undersigned does not accept a copy of the same at this point in time, he/she understands that he/she is bound by the terms of said Notice of Privacy Practice of Serenity Now and may request a copy at any time.

7. Teaching facility: The undersigned hereby acknowledges that Serenity Now is a teaching facility and therefore often has student interns involved in the treatment team process. This may include having interns observe and/or participate in therapy sessions and medication management visits. All student interns are held to the same standards as any other Serenity Now staff member and sign confidentiality agreements in compliance with all HIPPA regulations.

8. Appointments: That the undersigned understands that it is necessary for a treatment plan to be followed and a lack of compliance with the treatment plan or failure to attend, or, in the alternative to cancel more than 24 hours in advance 3 appointments within a 6-month period may result in termination of services. I further understand that I will be charged a fee of $25.00 for any missed appointments that are not cancelled more than 24 hours in advance. This charge will have to be paid in full prior to any future appointments being scheduled.

   As part of the treatment plan to be followed, drug screens may be required. If any drug screen is ordered, it shall take place within forty-eight (48) hours of the request, excluding Saturdays, Sundays and legal holidays.

   Serenity Now will notify the undersigned in the event there is termination of services and will provide names of other local providers.

9. Current Information: The undersigned agrees to provide current address and telephone number(s) and in the event these change, it shall be the responsibility of the undersigned to present that information to Serenity Now.

10. Permission to Call: That the undersigned further agrees that Serenity Now shall have the authority to call me at the telephone number(s) provided to remind me of appointments.

   THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, RECEIVING A COPY OR OFFERED A COPY THEREOF, AND IS THE PATIENT, OR IS DUTY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Client Signature: ____________________________
(If client is a minor or unable to sign, the person who is taking the responsibility must sign below)

Responsible party: ____________________________
Relationship: ______________________________
Date: ____________________________
Serenity Now Psychiatric & Counseling Services
(A Division of Hoosier Uplands Economic Development Corporation)
2125 16th St. Bedford IN. 47421
(812) 275-4053

Consent for Release of Prescription History

I authorize Serenity Now to access my prescription history from unaffiliated medical providers, insurance companies, pharmacy benefit managers and the SureScripts database, to help keep my medical record as complete as possible. I understand that my prescription history from other sources may be viewable by the providers and staff within Serenity Now, and may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

__________________________  _______________________
Printed Patient Name        Date

__________________________
Signature

My preferred pharmacy is __________________________________________

Location: _______________________________________________________


Information Release Form
Only for patients 18 yrs and older
(HIPAA Release Form)

Patient Name: ___________________________ Date of Birth: ___/___/____

[ ] I give authorization for Serenity Now to release the specified protected health information to
the following individual(s):

[ ] Spouse ___________________________ Date of Birth ___/___/____
   [ ] Appointment Information / Prescription Pick-Up
   [ ] Lab and Test Results
   [ ] Diagnosis and Treatment Information
   [ ] All Protected Health Information

[ ] Child ___________________________ Date of Birth ___/___/____
   [ ] Appointment Information / Prescription Pick-Up
   [ ] Lab and Test Results
   [ ] Diagnosis and Treatment Information
   [ ] All Protected Health Information

[ ] Other ___________________________ Date of Birth ___/___/____
   [ ] Appointment Information / Prescription Pick-Up
   [ ] Lab and Test Results
   [ ] Diagnosis and Treatment Information
   [ ] All Protected Health Information

__________________________________________
Printed Patient Name

__________________________________________
Date

__________________________________________
Signature

Revised 1/18
MINOR CHILD CUSTODY AND RELEASE
Information Release Form

Patient Name: ______________________________ Date of Birth: ___/___/____

Biological Parents/Legal Guardians: ____________________________________________

[ ] I give authorization for Serenity Now to release the specified protected health information to the following individual(s):

[ ] Step-parent ______________________________ Date of Birth ___/___/____

[ ] Appointment Information / Prescription Pick-Up
[ ] Lab and Test Results
[ ] Diagnosis and Treatment Information
[ ] All Protected Health Information
[ ] Make any decisions related to my child’s treatment in my stead

[ ] Step-parent ______________________________ Date of Birth ___/___/____

[ ] Appointment Information / Prescription Pick-Up
[ ] Lab and Test Results
[ ] Diagnosis and Treatment Information
[ ] All Protected Health Information
[ ] Make any decisions related to my child’s treatment in my stead

[ ] Other ______________________________ Date of Birth ___/___/____

[ ] Appointment Information / Prescription Pick-Up
[ ] Lab and Test Results
[ ] Diagnosis and Treatment Information
[ ] All Protected Health Information
[ ] Make any decisions related to my child’s treatment in my stead

Printed Patient Name ____________________________ Date __________________________

Signature ____________________________ Revised 3/19
Controlled substance medications (i.e. Benzodiazepines, stimulants) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. In the event that I am prescribed a controlled substance medication, I agree to the following:

1. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if I increase the use of my medication without prior approval from the office, I understand that this medication may not be replaced regardless of the circumstances.

2. I understand that many of these medications are intended for short term use as needed.

3. I agree to sign a release of information for my primary care physician and other pertinent prescribers.

4. I agree to report all medications being prescribed to me by other providers. I understand that failure to do so could result in discontinuation of controlled substance medication prescribing by Serenity Now and potential discharge from services.

5. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining pills.

6. I understand that if I need refills, I must call ahead within 72 hours to schedule an appointment.

7. I agree to comply with random urine or oral drug testing and pill counts, thereby, documenting the proper use of any medications.

8. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, overdosing on the medication or in combination with the use of non-prescription illicit (illegal) drugs, I may also be reported to my primary care physician and other pertinent prescribers.

9. I understand that the long term advantages and disadvantages of chronic benzodiazepine and stimulant use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances.
10. I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

11. I understand that some individuals may develop a physical dependence and/or addiction to these medications. This may occur if I am on the medication for several weeks. Stopping these medications too quickly can result in adverse reactions that could be potentially life threatening. Therefore, I agree to seek medical supervision before stopping any prescribed medications.

12. All controlled substances will be written for only one month at a time. While on a controlled substance I will be seen in the office every 1-3 months.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice evidence-based medicine in the safest and most efficacious manner possible while complying with all local, state, and federal regulations.

Patient Signature ___________________________________________ Date ________________