Oceanic Psych Wellness PLLC
1525 S Willow St., Unit 17, Manchester, NH 03103
Phone: 603-836-0488 Ext 101, Fax: 603-782-4360

Controlled Medication Contract

This agreement is a binding ontract between you and your provider. You enter this agreement with the knowledge that this medication listed may be habit-forming with long-term use. This is a decision that has been made after discussing the risk and benefits of this treatment, as well as the alternatives to this treatment.

The terms of this contract, listed below, are non-negotiable and failure to observe these terms will result in discontinuation of prescriptions for controlled substances and may result in discharge from this practice.

Example: All Stimulants, Narcotics

Medications/instruction: Narcotics or stimulants
Dispensing schedule: Per provider's prescription plan
Pharmacy: Patient's preference

Terms

1. Prescriptions for these medications listed above will only be provided by your provider at Oceanic Psych Wellness PLLC. If, in the event of surgery, emergency trauma or acute medical condition, controlled substances are prescribed by a physician other than at behavioral health, you will notify behavioral health promptly. You must phone during regular office hours at 603-262-3910, and report what controlled substances were received and the reasons for the additional treatment. Any controlled substances received should be filled at the pharmacy reported to OPW during your initial psych evaluation or reported if changed.
2. You need to choose one and only one pharmacy to fill these medications (listed above). A copy of this contract will be faxed to this pharmacy if necessary. Behavioral Health meeting writer only call any pharmacy in our area to ensure that you are not filling prescriptions for any other controlled substances outside of those medications we are prescribing you (or that you have told us about from another provider).
3. Timing and dosage of these medications will be agreed upon between you and your provider. **No changes in dosage may be made without the consent of both you and your provider** at scheduled appointments. If you do not feel your medication or dosage is effective, you should discuss this with your provider. Multiple phone calls requesting refills or demanding early refills or a change in dose are not appropriate and may result in a discontinuation of your controlled substance prescription.
4. You have responsibility for the safety of your medications at all times. There are **no acceptable** excuses for missing, lost or stolen medications.
5. Please do not expect to receive additional medication prior to the time of your next scheduled refill, even if your prescription runs out or if it is reportedly lost, missing or

stolen. You are responsible for keeping track of this amount of medication left and you must plan ahead in order to receive refills in a timely manner.

6. Random lab/drug testing and pill counts may be used to monitor drug levels, adherence, and effectiveness. Patient on medication contract may be called at any time and asked to come in for drug testing or pill counts. Failure to come in within 24 hours of provider's request for pill count or urine screen will be considered a violation of your contract. Prove of illicit drug use found through random testing may result in termination of this contract.
7. You must notify us immediately of any change in your contact information. We must have a valid phone number on file for you at all times where you can be reached.
8. All staff members are to be treated with respect. Violence or overly demanding behavior toward any staff member will not be tolerated. Aggressive or threatening verbal statements, gestures or body language grounds for termination of this contract, as well as dismissal from the practice. The police may be contacted at any time if unlawful behavior is observed.
9. You must follow your prescribed treatment plan developed with and signed by you. Failure to attend other prescribed services such as therapy, case management or functional support will result in discontinuation of prescriptions and may result in discharge from the program.

I have read and understand this document and agreed to all the terms listed above. My signature on this contract indicates I agree to these terms

Patient name: **D.O.B**:

Patient signature: **Date**:

Provider name: Dr Mary A. Eweka (DNP)

Provider signature: **Date**: