Advanced Psychiatry of Elgin

Child, Adolescent and Adult Psychiatry
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MED MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.
I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship that my doctor undertakes to treat me based on this Agreement.
I understand that if I break this Agreement, my doctor will stop prescribing these medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.
I will not drink any alcohol while taking psychotropic medication. I will not share, or trade my medicine with anyone. I will obtain all controlled medicines including controlled stimulants, sleeping pills, and anti-anxiety medicines from only one physician.

I will safeguard my medicines from loss or theft. **Lost or stolen medicines will not be replaced.**

I agree that refills of my prescriptions will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
I authorize other doctors and any/all pharmacies to cooperate and release any prescription records to Advanced Psychiatry of Elgin and to any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, other diversion of my medicine. I authorize my doctor to provide a copy of this Agreement to any pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this date:_____

_____
Patient Signature

_____
Parent/Legal Guardian

_____
Witness