DrJohnCantwell.com

Cantwell Family Psychiatry, PC
770 Middle Street, Fairhope, AL 36532
Mon – Thurs | 8am – 5pm | 251-517-5800

Prescription and Controlled Substance Agreement

The purpose of this agreement is to be certain that prescription and controlled substances are prescribed in the safest, most effective manner in compliance with current local, state and federal law. Dr. Cantwell requires that you sign this Agreement in order to facilitate the trust and confidence vital to a successful doctor/patient relationship.

- ⊕ I understand that breaking this agreement may be cause for termination from Cantwell Family Psychiatry.
- ⊕ I understand that Dr. Cantwell has the right to discontinue prescriptions and controlled substance medications at any time, especially if he suspects abuse of them or non-compliance with treatment.
- ⊕ I understand that Dr. Cantwell, if deemed clinically necessary, may taper me off medication over a period of time to avoid serious withdrawal symptoms.
- ⊕ I understand that, if necessary, I may be referred to a drug-dependence treatment facility or program.
- ⊕ I agree not to obtain any controlled substances, including stimulants, anti-anxiety, or sleep medicines from any other physician, except if I am admitted to a hospital, or if provided by a pain management provider.
- ⊕ I agree to disclose all medications I am taking, and failing to may also result in termination from this practice.
- ⊕ I agree not to share, sell or trade my medication with anyone.
- ⊕ I agree to safeguard my medicine from loss or theft, understanding that lost or stolen prescriptions will not be replaced, or refilled early.
- ⊕ I agree to inform Dr. Cantwell in detail of any past or present substance abuse.
- ⊕ I agree not to use illegal substances (e.g. methamphetamine, cocaine, heroin, etc.).
- ⊕ I agree to obtain a drug screen, if Dr. Cantwell requests one, and I will pay for the costs associated with it.
- ⊕ I agree that prescription refills will be made only during an office visit or regular office hours, Monday – Thursday 8-5 pm or Fridays 8-noon. No refills will be available during evenings, weekends, or holidays.
- ⊕ I authorize Dr. Cantwell to provide a copy of this Agreement to my pharmacy, if necessary.
- ⊕ I authorize Dr. Cantwell to cooperate fully with any city, state or federal law enforcement agency, including the DEA or Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my medicine.
- ⊕ I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered.
- ⊕ In the event I am dismissed from the practice for failure to abide by this Agreement, I agree to hold Cantwell Family Psychiatry harmless from any liability related to this Agreement.
- ⊕ I have read, understood, and I agree to abide by this Agreement.

Patient Name (Please print): _____ Date: _____

Patient Signature: _____

Dr. Cantwell's Signature: _____ Witness: _____