



NEW PATH PSYCHIATRY
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Controlled Substance Agreement Form

I, _____, understand and agree to the following terms regarding the prescription and use of controlled substances in my treatment:

- I acknowledge that I have been informed about the risks and benefits of controlled substances, including the
- potential for addiction, dependence, and overdose.
- I understand that my provider may request blood work and urine drug screens as part of my treatment plan,
- and I agree to comply with these requests.
- I understand that my provider is not obligated to restart or continue medications prescribed by other
- healthcare providers. Any decisions regarding medication changes will be discussed during my sessions.
- I agree not to seek or obtain the same medication from other healthcare providers while under the care of
- Providers at **NEW PATH PSYCHIATRY**.
- If I require new medication prescribed by another healthcare provider (PCP or ER), I will promptly inform
- my provider via the patient portal or email.
- I understand that Colorado state law regulates the prescription and use of controlled substances, and I agree
- to adhere to all applicable laws and regulations.
- I acknowledge that my provider will review my prescription history through the Prescription Drug Monitoring Program (PDMP) to ensure safe and appropriate prescribing practices.
- I agree to inform my provider at least one week before running out of medication to ensure timely refills.
- Early refills will not be provided for misuse or loss of medication.
- I understand the potential dangers of controlled substances to my health and well-being, and I will use them
- responsibly as prescribed.
- I hereby confirm that I have clarified with my provider that I have no cardiac history and no family history of cardiac illnesses such as heart attack and stroke.

I, _____ have read and understand the terms outlined in this Controlled Substance Agreement Form. I agree to abide by these terms for the duration of my treatment with **NEW PATH PSYCHIATRY**

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____