PRESCRIBED MEDICATION TREATMENT AGREEMENT

Due to the potential risks and benefit of taking prescribed medications (benzodiazepines, opiates, and stimulants) for treatment of mental health disorders, including ADHD or anxiety, this agreement will be executed to prevent misunderstandings and/or potential problems and as such, I agree to the following:

- I agree to **engage in therapy as recommended by my LifeStance treatment team**. My treatment team includes the medication provider, counselor, and any additional supports.
- I agree to **keep appointments with my treatment team** in order to receive any refills. I will not be eligible for a refill if I've not been seen by my prescriber in the previous 3 months.
- I will **not use any illegal controlled substances**, including heroin, methamphetamine, cocaine, etc. I will not misuse or self-prescribe legal controlled substances. While marijuana is legal for recreational and medical use, I will not use marijuana while engaged in treatment at LifeStance. I understand my medication provider may end prescribing this medication due to use of other substances.
- I will **not share my medication** with anyone.
- I will **communicate fully with my treatment team** about the intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve the symptoms. My provider **may require obtaining objective information** to determine whether the medication is effective.
- I will **not attempt to obtain any other controlled medications**, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.
- I will **safeguard my medication from loss or theft**. Lost or stolen medications will not be replaced. I should report any stolen medications to the police.
- I agree that **refills** of prescriptions for this medication **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 agree that I will **take my medications as prescribed**. Taking extra doses will mean that I will be without medication for a period of time. I will not ask for early refill of my medication.
- LifeStance will **work with a single pharmacy** for filling this prescription.
- I **authorize my provider and pharmacy to cooperate fully with any law enforcement agency**, including the Board of Pharmacy or the Prescription Drug Monitoring Program, in the investigation of any possible misuse, sale, or other diversion of my medication. My provider may give a copy of this Agreement to my pharmacy, primary care physician, or local emergency room. I agree to waive any applicable privilege or right of privacy with respect to these authorizations.
- I agree that I will **submit to a blood or urine test** if requested by my provider to ensure there are no problems with my use of prescribed medications.
- I will **bring unused medicine** to an office visit if requested.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____