Blue Sky Counseling Associates, LLC

1301 Oregon Ave.
Alamogordo, NM 88310
Phone: (575) 443-6166
Fax: (575) 437-0755
E-Mail: contact@blueskycounseling.net

Patient Name: _____

Medication(s):_____

_____

_____

Pharmacy: Name/Address/Phone: _____

_____

_____

Conditions I agree to the following:

- My prescriptions will be written as determined by my provider and filed at only one pharmacy
- I understand that my provider is under no obligation to provide these medications to me and that he or she reserves the right to discontinue these medications at any time.
- If I run out of my medication for ANY reason, I will see my provider for a re-evaluation
- Controlled substance prescription refills will be obtained during my regular office visit or at a special refill office visit.
- Only providers from Blue Sky Counseling Associates or approved specialists will prescribe controlled substances for me. If an emergency occurs, I will notify my provider as soon as possible that another doctor prescribed a controlled substance for me.
- Cooperate with random drug and alcohol testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.
- I may be asked to submit to random count of pills/ medications in my possession.
- Not following the provider's directions may result in discontinuation of this contract.
- Complications and the need for follow up have been discussed to my satisfaction.
- You will notify us if you are prescribed a controlled substance by another provider
- You must notify your provider at least five business days before your prescription runs out.
- Lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children.
- My provider may require specialist evaluations of my treatment and I agree to keep appointments when mt provider refers me. My provider will send a report of my care and a copy of this contract when a referral is made.

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This contract may be cancelled if:

- Any of the above conditions are not followed.
- Prescriptions are forged, sold, lost, or stolen.
- Other providers prescribe my controlled substance medication for me and I have not notified my provider.
- Anyone else has access to my medications.
- I do not keep my appointments with my provider.
- The condition changes for which the controlled substance is required

If cancellation occurs:

- The provider will slowly reduce and/or stop my medication and additional controlled substance will not be provided.
- I may be terminated as a patient

Alternative treatments: non-narcotic treatments to exist. Pain relief is often incomplete with controlled substances or medications alone. Other options may include treatment by professionals in behavioral health, physical therapy, or occupational therapy. These options have been discussed with me and may be required in this contract if deemed necessary by my provider.

I have read this controlled substance contract, understand it and agree to it in its entirety, I have taken a copy of this controlled substance contract with me.

Date:_____ Patient Signature:_____

Date:_____ Witness Signature:_____