HORIZON BEHAVIORAL HEALTH
*Hopeful, Helpful, Healing*

## Patient Psychiatric Medication Consent

**I am a patient under the care of Horizon Behavioral Health, PC, and its providers. Psychiatric medications, such as stimulants, benzodiazepines, antidepressants, and antipsychotics, can have serious side effects, especially when combined with other medications, illicit drugs, or alcohol. These side effects may include but are not limited to, nausea, constipation, drowsiness, abnormal thoughts or dreams, slowed reaction time, decreased sexual desire, allergic reactions, increased pain sensitivity, tolerance, physical dependence, addiction, withdrawal, and the potential for fatal overdose.**

**I understand that I have responsibilities when receiving and using psychiatric medications. I freely and voluntarily agree to this treatment contract as follows while on psychiatric substances prescribed to me at Horizon Behavioral Health, PC (HBH):**

1. I am responsible for all medications prescribed to me. If my prescription(s) is (are) misplaced, lost, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

2. Refills of medications will be made only during regular office hours Monday through Thursday, in person, and during a scheduled office visit. Refills will not be made at night, on weekends, or during holidays. I am solely responsible for taking the medication as prescribed and for keeping track of remaining medication and refills.

3. I understand that if I violate any of the above conditions, my prescriptions and/or my patient relationship may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, and medical facilities that have prescribed me medications.

4. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any medications that you have been prescribed. I understand that such mishandling of my medication is a serious violation of this agreement and it would result in my treatment being terminated without any recourse for appeal.

5. I understand that if dealing, stealing or any other illegal or disruptive activities are observed or suspected by employees of the pharmacy, they will be reported to HBH and could result in my treatment being terminated without any recourse for appeal.

6. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription. Tampering with a written prescription will be reported to the authorities.

7. I agree that my medication/prescription can only be given to me at regularly scheduled office visits. If I cancel or no-show a scheduled appointment, I will not be able to get my medication/prescription until the next scheduled visit.

8. I understand that I must tell Horizon Behavioral Health providers all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. Failure to disclose medications and/or illicit drug use can result in fatal medication interactions. We do not report illicit drug use to the authorities but need to know to avoid potential drug interactions. Some medications cannot be used with illicit drugs and treatment with these medications will cease if a patient continually uses illicit substances.

9. I agree not to obtain psychiatric medications from any other doctors, pharmacies, or other sources without telling my treating physician at HBH.

10. I agree to take my medication as my doctor has instructed and not to alter it in any way or change the way I take my medication without first consulting with my doctor. Taking medications in a manner other than as prescribed by the provider

can result in the medications and/or care being terminated.

11. I further understand that if I violate this psychiatric medication contract due to non-compliance of medical directions, such as failure to take medications as prescribed, utilizing other illicit drugs, or abuse of medications, I may be subject to dismissal from this facility.

12. I understand that medication alone may not be sufficient treatment for my diagnosed condition and I agree to consider all other treatments as discussed and specified in my treatment plan. All treatment plans are based on widely acceptable medical practice. If the patient does not agree with the provider's medical decision-making, the patient is free to seek a second opinion elsewhere. Disagreeing with treatment decisions does not entitle me to a refund of fees paid for that visit.

13. If I am prescribed medication by another provider I agree to inform him or her of all medications currently prescribed by the providers at HBH. I also agree to immediately inform the providers at HBH of medication prescribed by other providers outside of the HBH practice. HBH utilizes the Georgia Prescription Drug Monitoring Program to review all controlled substances filled by patients at pharmacies throughout the nation to support medical decision-making.

14. I agree to abstain from all illegal addictive substances, such as ecstasy, cocaine, heroin, methamphetamine, etc. I will not use, purchase, or otherwise obtain any other legal drugs without disclosing the use of such medications except as specifically authorized by my assigned provider at HBH or other providers I am under the care of. I agree that I will utilize alcohol in moderation while on medications and will abstain from use if instructed to by my HBH provider. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) that impair my driving ability, may result in DUI charges.

15. I understand that I am required to provide a urine sample and consent to urine drug testing at every appointment to document the proper use of any prescribed medications. Additionally, I agree to undergo other tests, such as pregnancy testing (biological females only) and routine blood testing, as a condition for receiving medications from my provider. Failure to comply with urine or blood testing will result in the termination of my treatment.

    If my insurance does not cover or requires payment, cost-share, copay, or deductibles for Therapeutic Urine Drug Screening, Pregnancy Testing, or Blood Work, I agree to pay for these tests out of pocket. I acknowledge that these payments may be required directly from the lab performing the test and that HBH does not set the prices or receive payment from outside laboratories. I understand and agree that I will be fully responsible for the cost of any tests not covered by my insurance as billed by the independent lab. HBH has no control over the payments charged by outside laboratories, and any billing discussions must be directed to the lab itself.

16. Refusal to provide specimens for testing (urine drug testing, pregnancy testing, or blood testing) or tampering with the provided specimen in any way will result in HBH not renewing prescriptions and/or care being terminated.

17. I understand that any violation of this contract may be grounds for termination of treatment.

18. I affirm that I have full right and power to sign and be bound by this agreement and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.]

19. I understand some medications require prior authorization from my insurance company before they can be filled. Prior authorizations can take 7-14 days (sometimes longer) for the insurance company to make decisions. I understand that not all prior authorizations will be approved by my insurance. If a prior authorization is denied I may have to come in to see the provider for an additional visit to discuss medication alternatives.

20. Aggressive behavior towards staff will not be tolerated. This includes assaulting (verbally or physically), excessively repeatedly calling the office for the same issue that has already been addressed, or waiting for a response from the provider. I understand that each call to the office for the same issue results in a delay of the provider answering the message.

    My signature below indicates I understand the above and my responsibilities as a patient receiving medications from Horizon Behavioral Health and its providers. By signing below I consent to the above guidelines and I consent to provide specimens for pregnancy testing (biological females only), urine drug testing, and blood testing as deemed necessary by my provider.

Patient Name:_____ Date of Birth:_____

Patient / Legal Guardian Signature_____ Date:_____