# Alabama Behavioral Health Office Policies

The purpose of this agreement is to help you and your provider to comply with the law regarding medication management with controlled pharmaceutical medications. The following is a detailed list of all of our office policies regarding usage of medication, particularly controlled substances, and the regulations for scheduling and treatment compliance. Please read each item thoroughly and initial by each as confirmation that you understand and agree to the guidelines listed.

## Scheduling/Treatment Policies

_____ I understand that Alabama Behavioral Health, and its medical providers are by appointment only and do not accept walk-in appointments, and do not provide crisis or emergency services. If you are in a current crisis or emergency situation, please dial 911 to be safely transported to the nearest Hospital Emergency Room (ER) or contact Crisis Services of North Alabama's Suicide Hotline at 1-800-691-8426 or (256) 716-1000. The suicide hotline is available 24 hours a day, 7 days a week.

_____ I understand that it is essential for my care that I be present to my scheduled appointments and that if I cancel or miss three consecutive appointments, or if I fail to be seen for an extended period of time, in excess of three or more months, that my account with Alabama Behavioral Health will be considered inactive and I will be dismissed from the practice.

_____ I understand that I will be required to pay my copay at the time of the visit in full. Additionally, I understand that my account will be checked prior to each appointment to verify if there are any outstanding balances and I will be asked to pay any balances on my account at the time of each visit.

_____ I understand that any amount that is not covered by my insurance will be billed to me as my responsibility. I also understand that it is my responsibility to make sure that my insurance covers my visits and to verify if I have any deductible amounts prior to making an appointment with Alabama Behavioral Health.

_____ I understand that any balance on my account that is not paid within 60 days is considered outstanding and I will not be seen until that balance is paid in full.

_____ If I pay by check and the check is returned, I understand that I will be required to pay a $25.00 fee in addition to any bank charges.

_____ I understand that my appointment time is set aside for me and if I fail to give 24-hour notice or arrive 15 or more minutes late for my appointment, I will be charged a $40.00 fee and I will have to reschedule to be seen by my provider.

_____ I understand that it is my responsibility to notify the office of any changes to my personal information, including insurance changes, phone number updates, and address updates. Additionally, I understand that confirmation calls and texts are a courtesy and it is my responsibility to keep up with my appointment.

_____ I understand that in the event that I need paperwork to be filled out by my provider (FMLA, Disability Determination paperwork, Work Leave forms, Letters, etc.), that I will be charged for the provider's time taken to complete the forms.

## Medication Compliance Policies

_____ I understand that there is a risk of psychological and/or physical dependence, addiction and death associated with abuse and chronic use of controlled substances: benzodiazepines (Xanax/Alprazolam, Klonopin/Clonazepam, Ativan/Lorazepam, Valium/Diazepam, Serax/Oxazepam, etc.), sleeping pills (Halcyon/Triazolam, Ambien/Zolpidem-Tartrate, Lunesta/Eszopiclone, Sonata/Zaleplon, Restoril/Temazepam, etc.),Opiate detox medications (Subutex, Suboxone/buprenorphine, Zubsolv, Sublocade, etc.), controlled stimulant medications for ADD/ADHD (Adderall/Dextroamphetamine, Ritalin/Methylphenidate, Concerta/Methylphenidate, Focalin/Dexmethylphenidate, Vyvanse/Lisdexamfetamine, etc.), particularly when used together or with: alcoholic beverages, cocaine, methamphetamine, marijuana, cough syrups, or pain medications (Lortab/Hydrocodone, Butran patches, Bupan patches, Fentanyl patches, Roxycodone, Oxycodone/Oxycontin, Dilaudid, Morphine, Methadone, Tramadol, Soma, etc.).

_____ I will notify my prescriber immediately if any other prescriber adjusts or changes the dose of any medications that I am on, unless I am in the hospital. Upon discharge from any hospital or facility I will notify my prescriber of any changes to my medications.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. I understand that any use of alcohol or pain pills with benzodiazepines is not allowed.

_____ I agree that I will not share, sell, or trade my medications with anyone. I understand that controlled substances taken by anyone other than the patient will be considered drug diversion, and will result in my dismissal from the practice.

_____ I understand that it is my responsibility to safeguard my controlled substance medications from loss, theft, or unintentional use by others. I also understand that lost or stolen medications will not be replaced, unless we receive a filed police report of the theft and even then replacement will only be given if the medication is medically necessary.

_____ Any refills of my prescriptions for psychiatric medications will be made only at the time of an office visit or during regular office hours. I understand that medication refill requests are not considered an emergency and will not be accepted outside of office hours (evenings/weekends). I understand that it is my responsibility to maintain my medications and make sure that I have enough supply until my scheduled appointment. Outside of office hours, I will go to the nearest Emergency Room if there are medications that I need urgently.

_____ I will not obtain any controlled medications for mental health treatment, including opioid detox medications, stimulants, anti-anxiety medications, or sleep medications from any other prescriber. If any other prescriber suggests adjusting my medications or prescribing any controlled substances, I understand that it is required that I discuss this with Dr. Doody to ensure that the medication is appropriate for my treatment and that it is safe to take with my current medications.

_____ I understand that the prescribing physician prescribes medication at dosages and frequencies that are deemed appropriate for my treatment. I understand that it is a requirement for my treatment that I take my medication as prescribed. I agree that I will not decrease or increase any dosage or frequency of my prescribed medications without consulting my prescriber first.

_____ I understand that any tampering with a prescription (i.e. scratching out medications, altering medications, altering dosages, altering quantities, etc…) is illegal. I also understand that legal action may be taken in the event that any prescription I receive is found to have been tampered with.

_____ In the event that I am prescribed any detox medications, I understand that I will be required to bring unused detox medicine to every office visit.

_____ I understand that in the case that my controlled medication is to be discontinued, my provider will taper me off of the medication over a period of several weeks, as necessary, to avoid withdrawal symptoms. I also understand that a drug-dependence treatment program may be recommended if my provider feels that it would be appropriate for me.

_____ I understand that my provider will be verifying that I am compliant with any prescribed controlled substances by checking the Prescription Drug Monitoring Program website periodically throughout my treatment period. The Prescription Drug Monitoring Program will give detailed information as to when my controlled medications are filled, where they are filled at, and who has prescribed the medication. I understand that the doctor will use this information to ensure that I am remaining compliant with my treatment recommendations and my use of controlled medications.

_____ I understand that random urine drug screens will be performed to verify medication compliance. Refusal to comply with random urine drug screens is considered non-compliance with treatment and will result in the tapering and/or discontinuing of controlled medications, and additionally may result in dismissal from the practice.

_____ I understand that any abusive or aggressive behavior will not be tolerated and may result in the physician’s decision to taper and/or discontinue controlled medications, and additionally may result in dismissal from the practice.

_____ I understand that if I do not adhere to the policies listed in this agreement that my provider will stop prescribing me any controlled medications.

By signing this agreement I understand that I am agreeing to adhere to the policies listed in order to receive treatment from Alabama Behavioral Health. I understand that if I do not comply with the policies listed in this agreement that my provider will be unable to treat me and I may be dismissed from the practice. Additionally, by signing this agreement I acknowledge that all of my questions and concerns regarding treatment have been adequately answered. I understand that a copy of this signed agreement will be given to me for my records.

Patient Signature: _____

Patient Name (printed): _____

Date: _____

Provider Signature: _____

Provider Name (printed): _____

Date: _____

Witness Signature: _____

Witness Name (printed): _____

Date: _____