CONTROLLED SUBSTANCE POLICY
Shiraz Qalbani, M.D.

This form acknowledges that the use of a Controlled Substance medication for my psychiatric care was a decision made between Dr. Qalbani and myself because of my specific condition. By signing this form, I acknowledge, understand, and agree to the following conditions to make my treatment as safe and successful as possible.

☐ I am aware that the use of this medication has certain risks associated with it, including habituation and dependence. I have reviewed the risks and benefits information with Dr. Qalbani.

☐ I agree to help myself by actively participating in psychotherapy to reach my treatment plan goals, maintaining as healthy a lifestyle as possible, refraining from illicit drug use, and remaining compliant with medication treatment plan.

☐ I agree to notify my provider of any changes, emergency room visits, and/or acute psychiatric service visits, lost or stolen medication, or any other circumstances affecting my health and well-being.

☐ I agree to receive the prescribed controlled substance only from Dr. Qalbani. I will not seek this medication from any other provider, friend, relative, or non-prescriber while I am under psychiatric care at **Psychiatric Consulting of The Woodlands**, except during the case of hospital admission medication changes. I am aware that Dr. Qalbani has access to and will be reviewing my patterns of filling prescriptions through the Texas Controlled Substance Monitoring Program.

☐ I understand that I may be subject to alcohol and drug screening, and a positive screen may prevent refills and/or result in the termination of psychiatric services at **Psychiatric Consulting of The Woodlands**.

☐ **REFILL:** I understand the following refill protocol will apply unless I have made previous arrangements with my provider:
a.) Medication will not be refilled early, even if they have been lost, stolen, or destroyed.
b.) I understand that I have to meet with Dr. Qalbani to get a refill. There are no “call-ins” allowed for Controlled Substances.

I agree to keep all appointments with psychotherapy and psychiatric medication provider.

I understand that if I fail to comply with the guidelines in this agreement, Dr. Qalbani may terminate psychiatric services.

I have read this agreement, and I fully understand the consequences of violating this agreement. My provider has answered my questions, and I agree to the terms of this agreement.

By signing below, I acknowledge that I have read and will follow the above.

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PATIENT SIGNATURE **DATE**