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moukdad MEDICAL

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CONTROLLED SUBSTANCE TREATMENT AGREEMENT

The purpose of this agreement is to ensure safe, responsible, and medically appropriate use of controlled substances prescribed by Moukdad Medical. Controlled substances (including medications for ADHD, anxiety, pain, or sleep) can be helpful but also have potential for misuse.

Please review carefully and sign below to confirm your understanding and consent.

PATIENT RESPONSIBILITIES

I understand and agree to the following:

• I will take my medication **exactly as prescribed** and will not change the dose or frequency without my provider's approval.
• I will **use only one pharmacy** for controlled medications and notify Moukdad Medical if that pharmacy changes.
• I will **not share, sell, or give** my medication to anyone else.
• I will **not request early refills**; lost or stolen prescriptions generally will **not be replaced**.
• I will keep all **scheduled follow-up appointments** and participate in treatment monitoring (including refills, urine drug screens, or pill counts if requested).
• I will **inform all my healthcare providers** that I am taking a controlled medication.
• I will **store my medication safely** and out of reach of others, especially children.

OFFICE & PRESCRIPTION POLICIES

• Refills are only provided during regular office hours and may require up to **3 business days' notice**.
• No refills will be provided after hours, on weekends, or through the emergency line.
• Repeated missed appointments, early refill requests, or concerning behavior may result in discontinuation of controlled medications.
• Moukdad Medical may review prescription records in the **state prescription monitoring program (PMP)** as required by law.

TELEHEALTH PRESCRIPTIONS

Controlled substances will be prescribed via telehealth **only when clinically appropriate** and in accordance with state and federal regulations.

PATIENT AGREEMENT & ACKNOWLEDGMENT

I have read and understand the policies above. I agree to comply with this controlled substance agreement and to use medications responsibly under the guidance of my provider at Moukdad Medical. I understand that violation of this agreement may result in changes to or termination of my controlled substance prescriptions.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____