The Fresh Start Program
Waterstone Counseling Center

Dr. Thomas Abbenante, MD • Dr. Richard Goulding, MD
Dr. Marc F. Bono, Psy.D

BENZODIAZEPINE MANAGEMENT AGREEMENT

The decision to use benzodiazepine medications was made between my provider and myself because of my specific condition. When I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible (please initial each numbered item):

_____ 1. I am aware that the use of such medicine has certain risks associated with it, and I have reviewed the Benzodiazepine medication handout with my doctor.

_____ 2. I agree to help myself by following better health habits; exercising, controlling my weight, and avoiding the use of alcohol and tobacco, *because I realize that good health habits help me control my anxiety and depression.*

_____ 3. I agree to tell my doctor about all other medicines and treatments that I am receiving. I will not request or accept controlled substances/medications from any other physician or individual without talking about it with my provider while I am receiving a benzodiazepine medication (while I am receiving such medications from Dr./NP_____). To do so may endanger my health and our doctor-client relationship. The only exception is medication prescribed while I am admitted to a hospital.

_____ 4. I understand the following refill policy will apply, unless I have made previous arrangement with Dr./NP_____:

a. Medications will not be refiled early, even if they have been lost, stolen or destroyed.
b. Medications will not be refilled on Fridays, weekends, or holidays.
c. *Medications will not be refilled by other physicians or providers.*

_____ 5. Í agree to use _____ pharmacy, located at _____ for all my medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and inform my new pharmacy of my prior pharmacy's address and telephone number.

_____ 6. I agree to keep all scheduled appointments.

_____ 7. I must keep Dr./NP_____ fully informed of any changes, ER or PES visits, lost or stolen medications or any other circumstances affecting my health and well-being

_____ 8. I have been fully informed by Dr./NP_____ regarding the potential psychological dependence on a controlled substance, I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms,

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_____ 9. I understand that if I fail to comply with the guidelines in this agreement and on my prescription labels; if I obtain controlled substances elsewhere (even from a physician); if use illicit drugs; if I share controlled substances with others; or if I alter a prescription, our doctor-client relationship will be terminated.

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

_____ _____
Patient's Signature Date

_____
Patient's Name (Please Print)

☐ Copy given to patient

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