

Help... when life hurts

PROVIDER CONTROLLED SUBSTANCE PRESCRIPTION POLICY

The intent of this policy is to provide access to safe and effective controlled substances for legitimate patients in need of treatment, while minimizing the risk for development of addiction in patients through improved prescribing and dispensing practices. Improvement of patient outcomes and quality of life is sought through reduction of under treatment, overtreatment, and inappropriate use of controlled substances. Advancement of evidence-based approaches to identify, monitor, treat, and follow up with patients suffering from addiction, in addition to focused education and training of practitioners in recommended controlled substance prescribing and dispensing practices and administration of rescue medication (i.e. naloxone) are all critical aspects to patient treatment.

The policies of Kinsler Psychology are in compliance with the Florida Boards of Medicine, Nursing and Pharmacy and take into consideration the recommendations of the CDC, DEA, and model policies on the use of controlled substances from the Federation of State Medical Boards.

- Controlled substance prescriptions may be picked up at the office or e-prescribed.
- Prescriptions are given for only one (1) month at a time, so a new prescription will need to be picked up at the office each month. Therefore, no 90 days' supply of medications will be prescribed.
- For the first three (3) months, patients prescribed controlled substances will be seen on a monthly basis. Once stable and after treatment for three (3) consecutive months, the prescribing provider may recommend 2-3-month follow-up appointments. However, this will only be scheduled with the proper documentation.
- Prescriptions can only be picked up by the patient whose name is on the controlled medicine, unless we have a signed Release of Information form noting a specific family member can pick up the prescription on behalf of the patient. Minor children are not able to pick up prescriptions for parents.
- Patients should submit requests for refills with a minimum of seven (7) days before the medication will run out to give their provider enough time to respond to the request.

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- If there is any suspicious behavior including frequent or early refill requests or multiple “lost” prescriptions, we have the right to terminate the Controlled Substance agreement and refuse further prescription requests.
- We will run a report on the Florida Prescription Drug Monitoring Program (E-FORCSE) at each visit.

Patients on controlled substance treatments are required to sign a Controlled Substance Agreement. Some of the conditions of this agreement are:

- Patient will take this medication only as prescribed and will not change the amount or frequency without authorization from the prescribing provider.
- We will not provide early refills or provide replacement of lost or stolen medication.
- Patient may be required to submit to random urine or blood tests to assess compliance to and efficacy of the treatment.
- Patient-Provider relationship is terminated if regularly scheduled appointments are not kept or the prescribed treatment plan is not followed.
- Patient is required to confirm by signature that they have not given any false health facts and are not seeking treatment under false pretense.
- Patient is required to release Dr. Kinsler & Associates, LLC/Kinsler Psychology from any liability related to their misuse of the controlled substance prescribed.

CONTROLLED SUBSTANCE AGREEMENT

The State of Florida has laws governing the prescription of controlled substances. The drugs include all opioids (such as codeine, hydrocodone and oxycodone), sleeping aids, benzodiazepines (such as Valium, Xanax, and Ativan) and ADHD medications (such as Concerta, Metadate CD, Ritalin and Vyvanse).

To comply with Florida law, I acknowledge and agree to the following:

- Prescriptions for controlled substance medications can only be written for a 30-day supply.
- I will not use any illegal controlled substances, such as, cocaine.
- I will not share, sell, or trade my medication with anyone.

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- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written or filled, will not be replaced.
- I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. If requested by my provider, I will bring all unused medicine to every office visit.
- I must be seen by my doctor no less than every two (2) months to continue to get refills.
- I agree that refills of my prescriptions will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on weekends.**

- I will submit to a blood or urine test within one week of when requested by my provider to determine my compliance with these policies.
- I will communicate fully and truthfully with my provider about the character and intensity of my psychological condition and how well the medicine is helping with my condition.
- I will obtain all controlled medicines only from the provider listed below. If I see another provider who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to this office in the original bottle, even if there are no pills left.
- I acknowledge controlled substance medications have inherent risks associated with their use. These risks include but are not limited to the following: Physical dependence, Psychological dependence, potential for overdose and potential for withdrawal syndrome.
- I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.
- I agree to comply with the terms of this agreement. I understand that my provider has the right to discontinue prescribing me controlled substance medications and discharge me from care I do not comply with the terms of this agreement.

I hold Dr. Kinsler & Associates, LLC/Kinsler Psychology and its staff harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement.

All of my questions and concerns regarding treatment have been adequately answered and a copy of this document has been given to me.

Patient Name: _____ DOB: ____/____/____
Patient Signature: _____ DATE: ____/____/____

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