Cheney Psychiatric Associates, LLC
3901 Faulkner Drive
Lincoln, NE 68516

Controlled Substance Agreement

Patient Name: _____ Date of Birth: _____

Provider Name: _____

Medication (controlled substances): _____

(**Patient initial each numbered item**)

_____ 1. I am aware that there are risks associated with controlled substances that include the potential for tolerance, dependence, and withdrawal upon abrupt discontinuation. **I will take my medication only as prescribed**, **will not use other mood-altering substances, and will not take medications that are not prescribed to me.**

_____2. I agree to tell my provider about all other medicines and treatments I am receiving. **I will not request or accept controlled substances/medications from any other medical provider or individual** *without talking about it with my provider.* Doing so may endanger my health and provider-client relationship. The only exception is medication taken while I am admitted to a hospital.

_____3. I understand the following refill policy will apply, unless I have made previous arrangements with my provider:

- **Medications will not be refilled early, even if they have been lost, stolen or destroyed.**
- **Medications will not be refilled on Fridays, weekends, or holidays.**

_____4. I agree to **keep all scheduled appointments**.

_____5. I understand that it is **my responsibility to keep my medication secure**. If my medication becomes lost or stolen, I will inform the office.

_____6. I will not drink alcohol or use street drugs while taking a controlled substance medication.

_____7. **I understand that failure to comply with the above guidelines may indicate that the risks of the medications may outweigh the benefits which** may result in the medication being discontinued and/or the provider-patient relationship terminated.

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

Patient Signature: _____Date: _____

Provider Signature: _____ Date: _____

□ Copy given to patient
August 19th, 2026