# Lily Health and Wellness Center

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## Benzodiazepine, Stimulant, and Hypnotic Medication Agreement

**Patient Name:** _____

This agreement outlines the terms and conditions under which **Lily Health and Wellness Center Telepsychiatry** may prescribe benzodiazepines (e.g., Klonopin, Xanax, Ativan), stimulants, and/or hypnotic medications. These medications may be prescribed to manage psychiatric symptoms or medication-related side effects and to improve daily functioning.

Due to the risks associated with these medications, strict adherence to this agreement is required.

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## Important Information About Benzodiazepines

I understand that:

- Benzodiazepines are intended for **short-term or limited use**, as daily use may result in reduced effectiveness over time.
- Abrupt discontinuation may cause withdrawal symptoms, which can be **life-threatening** in some cases.
- There is a risk of **dependence and addiction**.
- Long-term use may cause side effects including memory impairment and increased risk of cognitive decline, including Alzheimer's disease.
- These medications are frequently misused and can be dangerous when taken improperly.

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## Patient Responsibilities

In consideration of receiving these medications, I agree to the following conditions:

- I will take medications **only as prescribed**, including dose and frequency.
- I will not change how I take my medications without prior approval from my provider.
- I will not request early refills.
- Lost or stolen medications **will not be replaced**.
- I will request refills only during regular clinical hours and at prescribed refill intervals.
- Prescriptions will generally be written for a **maximum 28-day supply**, unless otherwise specified.

- I will not obtain these medications from **any other provider** without prior approval from Lily Health and Wellness Center.
- I will keep my medication list accurate and updated with Lily Health and Wellness Center.
- I will attend all scheduled appointments with my psychiatric provider.
- I will not be prescribed controlled substances if I am currently receiving other controlled medications.
- I will not be prescribed controlled substances if I have a history of substance abuse.
- I will actively participate in my treatment plan, which may include individual therapy and/or group services.
- I will not use alcohol, marijuana, or illicit substances while taking these medications.
- I agree to **random drug screens and pill counts** when requested.
- I will not sell, share, trade, or give my medication to anyone and will store medications securely away from children.

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## Monitoring, Compliance, and Discontinuation

I understand that:

- Failure to comply with this agreement may result in **immediate discontinuation** of these medications.
- If drug screening or clinical assessment indicates misuse, non-adherence, or the presence of non-prescribed or illicit substances, my provider may discontinue controlled medications and transition my treatment to non-controlled or alternative therapeutic options.
- If pill counts suggest improper use, my provider will discontinue the medication.
- If there is no meaningful improvement in symptoms, my provider may discontinue the medication.
- Laboratory testing and/or EKG monitoring may be required during treatment.
- If medication discontinuation is required, benzodiazepines will be tapered in the **safest clinically appropriate manner**.
- My dosage may **not be increased** and may be reduced or discontinued at my provider's discretion.

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## Acknowledgment and Signatures

I acknowledge that I have read, understand, and agree to all terms outlined in this agreement.

**Patient Signature:** _____
**Date:** ____

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**Provider Name and Signature:** _____
**Date and Time:** ____