Piedmont HealthCare Psychiatry and Behavioral Medicine
211 South Tradd St.
Statesville, NC 28677
704-978-3570

ACKNOWLEDGEMENT OF NON-NARCOTIC CONTROLLED SUBSTANCE CONTRACT

I affirm that I have read and understand the Contract for Non-Narcotic Controlled Substance Prescriptions (Agreement) from Piedmont HealthCare Psychiatry and Behavioral Medicine. I agree to abide by the terms of this Agreement and have received a written copy of the Agreement. I understand that if I violate any of the conditions, my non-narcotic controlled substance prescriptions and/or treatment with Piedmont HealthCare Psychiatry and Behavioral Medicine may be terminated immediately.

I also affirm that I have the full right and power to voluntarily sign this Agreement and to be bound by this Agreement. I further affirm that all of my questions and concerns about the risks and benefits associated with my controlled medication and my responsibilities under this Agreement have been answered to my satisfaction.

I agree to only use one pharmacy for filling all of my controlled medications and give Piedmont HealthCare Psychiatry and Behavioral Medicine full permission to communicate with the pharmacist about my medical care and medications. The pharmacy I have selected is:

Pharmacy_____ City_____ Phone_____

_____ _____ Date_____
Print Name (Patient) Signature (Patient)

_____ _____ Date_____
Print Name (Provider) Signature (Provider)