Benzodiazepine Patient Agreement

Patient Name:

Date of Birth:

By signing below I agree to the following conditions during my treatment at _________. I understand that breaking this contract may result in my treatment being terminated.

- I have informed my medication provider of any past history of substance abuse or misuse.
- I understand that benzodiazepines can interact with other substances especially sedatives; therefore, I will inform my medication provider of any other medication or drugs I am taking – both legal and illegal
- I understand that benzodiazepines are drugs of dependence. The risks of dependence, tolerance, and side effects such as cognitive impairment due to this medication have been explained to me.
- I understand that no replacement or early prescriptions will be provided to me. Looking after medications and prescriptions is my responsibility.
- I agree to take the medication as prescribed.
- I agree to attend my appointments regularly.
- I agree to submit to urinalysis screening as needed as determined by my medication provider.
- I understand that the benzodiazepine medication is only part of my treatment and agree to pursue other appropriate management measures as discussed with my medication provider.

I have read this agreement and understand it.

Patient Signature _______________________________________

Provider Signature _______________________________________