Angela Magill DNP Psychiatry PLLC

CONTROLLED SUBSTANCE AGREEMENT

By signing below, I acknowledge that I have thoroughly read and comprehend the following terms. I consent to adhere to these conditions regarding the use of controlled substances.

I understand that the use of marijuana may result in potential side effects, including but not limited to: dizziness, anxiety, confusion, sedation, low blood pressure, impaired short-term memory, euphoria, difficulty in completing complex tasks, suppressed immune system, lack of concentration, impaired motor skills, paranoia, psychotic symptoms, apathy, depression, and restlessness. I am aware that medical marijuana may worsen schizophrenia in individuals predisposed to the disorder. Additionally, I acknowledge that medical marijuana usage might lead to excessive talking or eating, altered time and space perception, and impaired judgment.

In case I experience any of the aforementioned side effects or encounter respiratory issues, disruptions in normal sleep patterns, excessive fatigue, heightened irritability, or social withdrawal, I commit to promptly contacting Angela Magill DNP Psychiatry PLLC.

I acknowledge that the full extent of medical marijuana's risks, benefits, and interactions with other drugs is not yet comprehensively understood. Should I be undergoing medical treatment or using medications for any health condition, I acknowledge the necessity to consult my treating physician(s) before incorporating medical marijuana and not discontinue any prescribed treatment without their counsel.

Pregnancy and breastfeeding: I understand that consuming medical marijuana orally or through inhalation during pregnancy and breastfeeding is unsafe. The presence of tetrahydrocannabinol (THC) in marijuana can transfer to breast milk. **As a female of childbearing age, I pledge to promptly inform my doctor if pregnancy is possible or confirmed.**

I commit to providing my doctor with a comprehensive and accurate medical history, including previous medical treatments, current medications (prescription, over-the-counter, or herbal supplements), and any history of substance addiction or dependency. Should it be discovered that I have provided false or misleading information, the medical marijuana recommendation may be revoked. I am aware that my referring provider and the Department of Health will be notified of any fraudulent actions.

I am cognizant of alternative treatments that do not involve controlled substances, such as weight management, exercise, avoidance of tobacco and alcohol, physical therapy, massage therapy, biofeedback, cognitive therapy, psychotherapy, non-opioid pain relievers, nerve blocks, and surgical interventions.

I agree to adhere to the prescribed usage instructions for my medical marijuana, utilizing it solely for its intended purpose. I understand that misuse, higher dosages, combining medications without my provider's knowledge, or interruptions in medication supply may negatively impact my health.

I pledge not to engage in any illegal sale, possession, distribution, or transportation of controlled substances. I will refrain from sharing, selling, trading, or hoarding my medical marijuana with others. I

am aware that my medication can pose harm to individuals, particularly children and animals, and I will store it safely.

I consent to undergoing blood, saliva, and/or urine tests as requested by my provider, even during appointments. I agree to appear within 48 hours of the test request and understand that I am financially responsible for these tests if not covered by my medical insurance. I grant permission for my provider to share my drug test results with other treating physicians.

I authorize both my provider(s) and pharmacist to cooperate with law enforcement agencies and regulatory bodies, including city, county, state, or federal entities, in investigating potential misuse, sale, or diversion of my medical marijuana. I acknowledge that my confidentiality rights concerning my health information may be waived in this context.

Medical Marijuana Medication Recertification: I am aware that my certification starts on the certification date and lasts until the end date determined by my provider, which could be up to a year. I am responsible for seeking a new certification within 30 days of its expiration to avoid interruptions in accessing medical marijuana.

I understand that if I am unable to afford my medical marijuana treatment, I will not hold Angela Magill DNP Psychiatry PLLC responsible.

I acknowledge that my certification and prescription are based on my medical history and my provider's expertise. If adjustments to my prescribed ratio are needed for better outcomes, I agree to collaborate with my provider. Pharmacist recommendations will not be accepted by Angela Magill DNP Psychiatry PLLC.

By signing your name below, you are agreeing to abide by this agreement in its entirety.

Patient Signature: ____ Date: ___________________

Patient Name (PRINT): ___________________________________

(If under 18 years of age, please have parent/guardian sign)

Parent/Guardian Signature: ______________________________ Date: ___________________

Parent/Guardian Name (PRINT): _________________________

Informed By: Angela Magill DNP Psychiatry PLLC

Witness: ______________________________ Title: ___________________

Signature: ____________________________ Date: ___________________