ADHD TREATMENT AGREEMENT

Patient's Name:_____

Patient's DOB:_____

- Treatment Plan*
    - ☐ I understand that:

      --behavorial care is not mixed with well or urgent care and my child must have a yearly well care exam and a medication check appointment at least once every three months (minimum of four visits per year).

      --urgent care (cold, sore throat, abdominal pain, etc.) does not replace a three-month medication follow-up appointment.

      --the physician **MAY** monitor my child's symptoms and side effects every 6 months using the Vanderbilt questionnaires.

      --a behavioral screening must be completed at each visit.

- Controlled Substances*
    - ☐ I understand that stimulant medications (Ritalin, Adderall, Concerta, Vyvanse, etc.) are classified as controlled substances by the FDA and closely monitored by the Drug Enforcement Administration (DEA).

      BY LAW, these medications:
      - **CANNOT** be automatically refilled.
      - **CANNOT** be phoned or faxed to a pharmacy.
      - **MUST** be picked up in person, with ID verification.

- Lost or Stolen Prescriptions*
    - ☐ I understand that if any of the issued prescriptions for stimulant medications are lost or stolen, a police report MUST be filed and a copy sent to our office BEFORE replacement prescription(s) are issued.

- Required Follow-up*
    - ☐ I understand that my child will need to complete a medication follow-up appointment at least 5 days BEFORE the completion of their medication supply. Additional perscriptions CANNOT be issued until the medication follow-up appointment is completed.
- Failure to Comply*

☐ I understand that if I fail to comply with this agreement, the physician may discontinue medication and/or treatment

Name of Parent or Legal Guardian: _____

Relationship to Patient: ____ Mother

____ Father

____ Other _____

Email me copy of this agreement?

____ Yes

____ No

Signature of Parent or Legal Guardian: _____

Date: _____