Controlled Substances Treatment Agreement

Stimulant (narcotic) treatment for ADHD is used to decrease your ADHD symptoms and to improve what you're able to do each day. Along with this treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic medication, psychological counseling or other therapies or treatment.

I, _____, understand the compliance with the following guidelines is important in continuing ADHD treatment with the Center for ADHD, Inc. I understand that I have the following responsibilities and agree to adhere to all of the following rules while I am under the care of the Center for ADHD, Inc.:

1. I will take medications as prescribed.
2. I will not increase or decrease without the approval of my physician/APRN.
3. I will not obtain medications from several physicians, but my physician/APRN only. (Under certain circumstances, if I obtain any additional narcotic from other physicians such as primary care physician or emergency room physician, then I will immediately notify the Center for ADHD, Inc.)
4. I will not share the medication with anyone including family members.
5. I will not sell the medication.
6. I will not get replacement from any lost or stolen medication regardless of the circumstance.
7. I will not get early refills.
8. I will notify if I abuse alcohol or use other illicit drugs along with ADHD medication.
9. I agree to periodic random drug screening tests.
10. I agree to periodic random pill counts.
11. I agree to participate in adjunctive management programs such as: psychological testing, counseling therapy, behavioral modification, school based interventions, job modifications if recommended by the physician/APRN.
12. I will not request prescription refills when the clinic is closed after hours or on weekends.
13. If I am pregnant or intend to get pregnant, I am required to notify the Center for ADHD, Inc. immediately to discuss tapering off stimulants that could potentially harm the fetus. I understand that failure to do so may result in discharge from the clinic. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.

I, _____, understand that this physician/APRN may stop prescribing the medication or change the treatment plan if I failed to follow the above recommendations. I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of stimulants to help control my ADHD and I understand that my treatment with stimulants I will be carried out as described above.

_____ _____

Print Patient Name Patient Signature & Date

_____ _____

Print Witness Name Witness Signature & Date

_____ _____

Print Physician Name Physician/APRN Signature & Date