



CONTROLLED SUBSTANCE/ ADHD MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you or your child will be taking for ADD or ADHD. This is to help both you and your provider to comply with the law regarding controlled pharmaceuticals.

Provider location: Caswell Family Medical Center, Yanceyville James Austin Health Center, Eden

- I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my/my child(s) provider undertakes to treat me/my child based on this Agreement.
- I understand that if I break or do not comply with this Agreement, I/my child may be terminated from receiving care at Compassion Health Car (CHC) after 30 days which allows me time to find another provider. I/my child will, however, be seen for emergency (life threatening) conditions that may develop during this 30-day time period.
- I will communicate fully with my/my child's provider about the character and intensity of the condition, the effect on daily life and school, and how well the medicine is helping to improve presenting symptoms.
- I will comply with my/my child's provider in completing necessary routine assessments, including ensuring teachers receive forms required to assess my child's academic performance.

For Adult patients only:

- **I will not** use any illegal controlled substances, including marijuana, cocaine, etc. **I will** limit my use of alcohol as it may increase the side effects of my medicine.
- **I will not** share, sell, or trade the prescribed medication with anyone.
- **I will not** attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider outside of CHC.
- **I will** safeguard my/my child's medicine from loss or theft. Lost or stolen medicines will not be replaced. **I will** keep the medication out of the reach of children.
- **I agree** that refills of prescriptions for ADD/ADHD medicine will be made only at the time of an in-office scheduled visit. No refills will be available during evenings, weekends, as a walk-in, or over the phone.
- **I agree** to use the following Pharmacy:
Pharmacy Name: _____
City _____ State: _____ Zip: _____ Phone: _____ / _____ / _____
- **I authorize** the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this stat's Board of Pharmacy, and to contact any pharmacies in the investigation of any possible misuse, sale, or other diversion of my medicine.
- **I authorize** my/my child's provider access to any State controlled substance registry.
- **I authorize** my/my child's provider to provide a copy of this Agreement to my pharmacy.
- **I agree** to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- **I agree** that I or my child will submit to a blood or urine test if required by my provider to determine my compliance with my program of ADD/ADHD control medicine.
- **I agree** that I or my child will use medicine at a rate no greater than the prescribed rate and that use of the medicine at a greater rate will result in my/my child being without medication for a period.
- **I WILL BRING ALL PRESCRIPTION BOTTLES TO EVERY OFFICE VISIT.**
- **I agree** to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 20_____

Patient Name: _____

Print Parent/Guardian name, if different from patient: _____

Parent/Guardian Signature: _____

MR #: _____ Date of Birth: ____/____/____

Provider's Signature: _____

Witnessed By: _____