The ADD/ADHD Diagnostic & Treatment Center, PA

Please read and initial.

_____ I agree to take my medications **as prescribed** by the doctor.

_____ I understand that I am putting myself at risk for psychological dependence or addiction if I abuse my medication.

_____ I understand **refills are sent on the scheduled dates** and we are to account for each and every pill.

_____ I agree to receive ADHD medications from only ***One doctor*** and one pharmacy.

_____ I understand it is at my doctor's discretion to schedule weekly, monthly, bimonthly, or every three months for medication management.

_____ I understand I have ***21 days*** from the earliest filled date to fill my prescription. Expired prescription may be replaced at physician's discretion and it is subject to a **$15.00** fee.

_____ ***For a STOLEN prescription***: a copy of the police report is needed. There is **no fee** to replace the prescription.

_____ ***For a LOST prescription***: a copy of the police report and a signed patient statement are required. **$15.00** fee is applied to patient account.

_____ I understand my doctor may review controlled substance prescription records via Texas Prescription Monitoring Program at any time during the course of treatment.

_____ **I understand altering any paper prescription is against the law.**

_____ **I understand selling, sharing, or giving my medication to anyone is against the law.**

_____ **I am responsible for safeguarding my medication against loss, theft, or inadvertent use by others. Per Health and Safety Code, title 6, subtitle C, chapter 481 subchapter D. sec 481.101**

REGARDING URINALYSIS TESTING & DRUG SCREENINGS:

_____ I realize that I am subject to random urine drug screens in-office or at Quest/Labcorp.

_____ I understand and agree to office drug screening protocols. If my test is positive for illegal drugs or negative for the prescribed drug I understand that I will be subject to immediate dismissal from the practice on the third occurrence.

I understand that the purpose and intent of this agreement is to comply with State and Federal regulation to protect my physicians and myself from any misunderstanding regarding my use of controlled substance in the management of my medical treatment. I further understand that violation of this agreement may cause my termination from the ADD/ADHD Diagnostic & Treatment Center, PA, with the usual notice by certified letter and 30 days of emergency care until a new practitioner can be chosen.

_____	___/___/___	_____
Patient or Parent/Guardian Signature	Date	Print Parent/Guardian Name
_____	___/___/___	_____
Print Patient Name	Date of Birth	Witness