Desert Shores Pediatrics Stimulant/Non-Stimulant Medication Agreement

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____ Date: _____ Provider Name: _____

Desert Shores Pediatrics (DSP) is committed to providing the safest care for our patients with Attention Deficit Hyperactivity Disorder (ADHD). Drug Enforcement Agency (DEA) controlled substances may be used as a therapeutic option to manage symptoms associated with this condition. The following agreement is designed to help improve treatment outcomes, reduce the risk of adverse events and ensure proper use of all ADHD medications while adhering to both state and federal laws. The word "I", "me", or "my" refer to the patient; in cases where the patient is under 18 years of age, the parent or legal guardian is authorizing this agreement on behalf of the child.

1. I agree that Desert Shores Pediatrics will be the ONLY practice to prescribe stimulant and nonstimulant type medications for managing my ADHD.

2. I agree to take the medication at the dose and frequency prescribed by my provider and I agree NOT to change the dose of my medication without first discussing it with my provider.

3. I agree to be seen by the same DSP provider for ongoing follow-up evaluation and monitoring once I am stable on my medication. The suggested interval per Food and Drug Administration (FDA) guidelines is every 90 days, but may be adjusted at the provider's discretion on an individual basis.

4. I agree that any change in medication dosing will require a follow up visit in the office.

5. I agree that my provider may recommend other ADHD consultations, management strategies, or referrals as necessary to promote my desired outcome. I will make every reasonable effort to pursue these measures.

6. I agree that refill requests for my ADHD medications will be made only during a scheduled office visit dedicated to my medication monitoring or during regular office hours. All refill requests will be addressed within 72 hours. Walk-in requests for refills may NOT be accommodated.

7. Most ADHD medications can be sent via electronic prescription straight to the pharmacy, but there may be instances when a prescription needs to be picked up in person and a photo ID will be required. I agree that requests to mail prescriptions to my home will not be accommodated, unless specifically agreed upon by my provider.

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8. I agree that if I lose my medication, it will not be replaced, unless there is a documented extenuating circumstance. My provider reserves the right to deny another prescription and/or to stop prescribing my ADHD medication if loss of medication is a recurring problem.

9. I agree to be responsible for the secure storage of my medication. I agree not to give or sell my medication to any other person.

10. I agree that if my health insurance does not cover the cost of mental health services, including treatment of ADHD, I will be responsible for the full cost of treatment including ongoing evaluation and management by my DSP provider.

11. I agree to maintain yearly well visits/physicals for my child, as recommended by the American Academy of Pediatrics.

12. I acknowledge that if my ADHD medication management visit is scheduled with my well care visit, it will result in both the standard well visit charge plus an additional office visit charge.

13. For a child of separated or divorced parents, the custodial parent listed on this document is responsible for communication with the other parent regarding the child's diagnosis and treatment management, including this stimulant medication agreement, unless that parent's role is restricted by Court Order.

14. I agree that if I break this agreement my provider reserves the right to stop prescribing for me.

Patient/Parent/Guardian Signature: _____ Date: _____

Relationship to child: _____

Provider Signature: _____ Date: _____

_____ Patient/Parent/Guardian **refuses** to sign Stimulant/Non-Stimulant Medication Agreement.

Witness Signature for Refusal: _____ Date: _____ By DSP Staff Member