Pediatric Associates, PSC Stimulant (ADHD Medication) Agreement

Date: _____

Patient Name: _____

Patient DOB: _____

Patient SS# or KY Drivers lic#: _____

To the Parent or Patient:
In accordance with 902KAR55:110, it is our policy at Pediatric Associates, PSC that patients (or their guardian) receiving prescriptions for controlled substances be required to sign a Controlled Substance Agreement. By signing this agreement, I agree or I agree to follow for my child:

- I agree to take the medication ONLY as prescribed and I will not change the dose without getting approval from my physician or provider.
- I will keep my medicine in a secure, safe place. Lost or stolen medicine will not be replaced. I will not share, sell or trade my medication. I will not use any illegal drugs or alcohol while taking this medication. I understand that taking prescription medications that have not been prescribed to me, or giving/selling/trading my stimulant medication to other people, is a federal felonious offense called drug diversion.
- I understand this medication has potential side effects including but not limited to: appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, and difficulty sleeping. These are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider. This requires regular office visits to follow my progress.
- I know that this medication is given to help control the effects of ADHD. It is not a cure. The duration of use is determined by the effectiveness of the treatment.
- I understand this medication is potentially addictive and chances of addiction are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider.
- I agree that this medication will be stopped if my ability to function does not improve, if the medication loses its effectiveness, if I do not attend required office appointments, or if there is reason to believe I am misusing the medication in any way.
- I have had the risks associated with taking this medication explained to me and have decided that the benefits outweigh the risks.
- If I am unable to take the medication due to allergic or otherwise adverse reaction, I will notify the prescriber and discard the remainder.
- I understand that if any of this medication needs to be discarded I contact my local police department to locate a drug disposal location.
- While taking any schedule II medications such as stimulant medications, yearly and random drug screens may occur for patients 16 and older. The test will be filed to

insurance and I understand that any out-of-pocket expenses for these screenings not covered by insurance will be my responsibility. All physicians/ providers are required by law to report any suspicion of prescription abuse.

- I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt referral for assessment for a substance abuse disorder or discharge from the practice.
- I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.
- I will notify my provider at least 3 working days before I will need a refill on my medication. No refills will be given outside of business hours. Prescriptions will be ordered electronically (e-scribed), and will not be mailed. Prescriptions will only be filled once every 30 days (or as directed by my provider). There will be no early refills.
- Regulations require in office medicine check-ups at minimum 1 month intervals until the medication and dosage is stable and then followup will be determined at the discretion of the provider. Please schedule in advance to avoid delays in getting needed medications.
- The law requires each patient receiving a controlled substance be enrolled into the state KASPER system. The state uses Social Security Numbers to track controlled substance prescriptions in Kentucky so your child's SSN (or driver's license if they have one) is required to enroll. We will not be able to fill future ADHD stimulant prescriptions until we have these items.
- I authorize Pediatric Associates, PSC to review medication information with other doctors, hospitals, and pharmacists.

_____

Patient Signature/ Date

_____

Parent Signature (if patient is under 18 years)/ Date