



ADD/ADHD TREATMENT CONTRACT

I, _____, am being treated for attention deficit hyperactivity disorder (ADHD). This treatment may involve the use of medications which are controlled substances, which can only be provided via a written prescription from a licensed healthcare professional at the above named facility.

-Initial Below-

_____ In order to adequately monitor my condition, I agree to see my medical provider at the BritePath Medical by appointment at least once every three months as directed by my healthcare provider.

_____ I understand that prescriptions for ADHD medication will only be given to me during appointment with my medical provider at the BritePath Medical.

_____ I understand that it is my responsibility to schedule my appointments in advance so that I am not at risk of running out of my medications.

_____ I agree to complete routine physical examination and intermittent diagnostic evaluations as seen fit by my healthcare provider as it related to my diagnosis.

_____ I understand that I will never receive a prescription refill early - even if my medication is stolen, destroyed, or otherwise lost.

_____ If I am unable to keep an appointment, I agree to notify the BritePath Medical at least 24 hours in advance. I also understand that it is my responsibility to reschedule the appointment so that I am not at risk of running out of my medications.

_____ I agree to follow my medical provider's instruction on how to take the medication.

_____ I agree to never request prescriptions to be given to me outside of a scheduled appointment, unless directed by my healthcare provider.

_____ I agree to random urine drug tests at the discretion of my medical provider.

_____ I agree to never sell or share my medications with anyone.

_____ I agree not to seek out other medical providers or seek prescriptions for these medication from anywhere else. The only exception is if I have been explicitly directed to do so by my medical provider or during a hospitalization.

_____ I agree to continually educate myself about my condition and pursue non-medication methods for controlling ADHD symptoms.

_____ I understand that I will be evaluated and treated by a Physician Assistant or Nurse Practitioner at all of my visits.

_____ I acknowledge that if I break any part of this agreement, my medical provider at the BritePath Medical will discontinue my management of ADHD and discharge me entirely from receiving care at the BritePath Medical.

Patient Name

Patient Signature & Date

Medical Assistant Initial