Bethesda Pediatrics

ADD/ ADHD Medication Contract

I, _____, have been prescribed medication for treatment of
(patient name)
ADD/ADHD. I understand that ADD/ ADHD medications are controlled substances that are regulated by state and federal law because of their high risk for abuse.

I understand that is a felony to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others.

I will not seek to have duplicate prescriptions for my ADD/ ADHD medications.

I am aware that:

- I will use my medications as prescribed and NOT adjust the dosage on my own.
- I will be required to have follow up appointments every 6 months on average, or more if directed by my prescribing physician.
- I will keep up to date on my yearly well check appointments.
- I will call and leave a message on the Prescription Line at least 48 hours in advanced when I need a refill.
- If I need any dosage adjustments, I am to speak directly to my prescribing physician or leave a voicemail for call back (if necessary).
- Prescriptions will not be written before 25 days from the last refill.
- No replacement for lost/ stolen prescriptions or medications will be provided.
- Prescriptions must be picked up, signed for and taken directly to pharmacy.

I acknowledge that violation of the Bethesda Pediatrics ADD/ ADHD policies concerning controlled substances will result in termination of this contract and the loss of ADD/ ADHD prescription privileges.

I acknowledge that I am responsible for protecting my prescription and my medication from being lost, stolen, or misused by other persons.

I acknowledge that it is both illegal and dangerous to share or sell prescription medications.

I have read and understood this contract and I agree to fulfill my obligations.

_____ _____/_____/_____
Print Patient Name Patient Date of Birth

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Parent Signature (if patient under 18 years old) Date