Compassion Services
484 Tollage Creek Road
Pikeville, KY 41501
Phone: 606-888-7337
Fax: 606-432-1616

Compassion Pediatrics Behavioral Health
Controlled Substance Agreement Contract

Patient_____ DOB:_____ Chart#_____

You, or your child, have been diagnosed by a health care practitioner as having Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). Medications used for the treatment of ADD/ADHD are control substances, the prescription of which is tightly controlled by the state/federal law.

Stimulant (controlled substance) treatment for ADHD is used to decrease your ADHD symptoms and to improve what you can do each day. Along with this treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include the use of non-narcotic medication, psychological counseling or other therapies or treatment if advised by the Psychiatric Mental Health Nurse Practitioner.
I, _____, (Guardian- unless 16 years of age and older) understand the compliance with the following guidelines is important in continuing ADHD treatment with the Compassion Pediatrics Behavioral Health. I understand that I have the following responsibilities and agree to adhere to all the following rules while I am under the care of the Pediatric Compassion Pediatrics Behavioral Health:

1. I will agree to an Electrocardiogram (EKG/ECG) at the initiation of treatment as well as annually or up to providers clinical judgement based off treatment progression/compliance.
2. I will agree to routine labs such as, but not limited to, urine screens, hepatic function, renal function, cardiac enzymes, pregnant test, etc. as deemed necessary by provider for treatment compliance.
3. I will take medications as prescribed and agree to following administration instructions/dosages set by provider.
4. I will not increase or decrease without the approval of my physician/APRN.
5. I will not obtain medications from several physicians, but my physician/APRN only. (Under certain circumstances, if I obtain any additional narcotic from other physicians such as primary care physician or emergency room physician, then I will immediately notify the Compassion Pediatrics Behavioral Health clinic.
6. After initiation of treatment, a follow-up visit for any reason, is REQUIRED MONTHLY, prior to the issuance of medication prescribed for the treatment of ADD/ADHD. NO REFILLS are allowed on controlled substances. There will be NO EXEPTIONS for this rule. In person, face-face is required for the initial visit, when a medication is changed, as well as every 3rd month, or at the provider discretion. Telehealth will be available for the months that in person face-to-face is not required, if provider agrees. For example, appointments should be face-to-face in person for the initial visit, medication changes from one medication to another, and as provider sees fit for treatment progression and compliance.
7. I will not share the medication with anyone including family members.
8. I will not sell the medication, or exchange medication with anyone other than what is prescribed to the patient. Please keep in mind this is illegal and charges can be pressed.
9. I will not get replacement from any lost or stolen controlled medications regardless of the circumstance.

PEDIATRIC BEHAVIORAL HEALTH
Compassion Pediatrics

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COMPASSION PEDIATRICS
of Pikeville, Kentucky

10. I will not get early refills for medication. Medication will be sent exactly 30 days from when active scripts lapses. This is a state law through the DEA and will be followed accordingly to laws and update as they change.
11. I will notify if I abuse alcohol or use other illicit drugs along with ADHD medication. The provider has the discretion to discontinue controlled substances at any time, and place patient on a non-controlled ADHD medication according to treatment needs.
12. I understand that failed drugs screenings on non-compliance with medications, breach this contract and the provider has the clinical judgement to remove patient from controlled substances and place on a non-controlled substance.
13. I agree to periodic random drug screening tests.
14. I agree to periodic random pill counts and agree to bring prescription bottles into each in person face-to-face appointment.
15. I agree to participate in adjunctive management programs such as: psychological testing, counseling therapy, behavioral modification, school-based interventions, job modifications if recommended by the Psychiatric Mental Health Nurse Practitioners.
16. If I am pregnant or intend to get pregnant, I am required to notify the Pediatric Associates of Compassion Pediatrics Behavioral Health immediately to discuss tapering off stimulants that could potentially harm the fetus. I understand that failure to do so may result in discharge from the clinic. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.
17. Medication prescriptions cannot be mailed, faxed, or called into the pharmacy. Prescriptions will be electronically prescribed to the pharmacy that is on file. I agree to take responsibility of notifying the Compassion Pediatrics Behavioral Health about updating my preferred pharmacy. It is the patients/guardian's responsibility to verify if medications are in stock at pharmacy prior to e-prescribing medications. If pharmacy is out of mediation, it is the patients/guardian's responsibility to call surrounding pharmacy and update preferred pharmacy during business hours and in a timely manner.
18. Medication prescriptions will remain valid for 30 days and cannot be filled at that time after those 30 days. Script will be cancelled at pharmacy if not picked up. Requests for medication refills may be submitted when the patient has 7 days of medication remaining, but WILL not be able to be filled at pharmacy until effective fill date that prescriber has placed under NO circumstances script will be filled early.
19. You are advised to promptly contact this office if you or your minor child encounters any potential adverse effects from the prescribed medications.
20. Any suspected inappropriate use/abuse of prescribed medications by your minor child is to be promptly reported to this office.
21. If your health insurance does not cover the cost of mental health services, including the treatment of ADD/ADHD, the patient/parent will be responsible for the full cost of treatment.
22. Please list persons (other than yourself) allowed to receive information about the above patient. (name, contact information, relationship)
    - _____
    - _____

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I, _____, (Guardian, unless patient is 16 years or older) understand that this Psychiatric Mental Health Nurse Practitioner may stop prescribing the medication or change the treatment plan if I failed to follow the above recommendations. I have read this document, understand, and have had all my questions answered satisfactorily. I consent to the use of stimulants to help control my ADHD and I understand that my treatment with stimulants will be carried out as described above.

X_____ _____
Signature of patient (ages 16 years or older) Date:

X_____ _____
Signature of legal representative for patient under 16 Date:

X_____ _____
Physician/PMHNP-BC Date: