



Controlled Substance Contract for ADHD Therapy

Patient name: _____

DOB: _____

Parent/Guardian Name: _____

Date: _____

Provider Name: _____

Rainbow Kids Clinic is committed to providing the safest care for our patients with Attention Deficit Hyperactivity Disorder (ADHD). The following agreement is to help improve treatment outcomes, reduce the risk of adverse events, and ensure proper use of medication(s) while adhering to both state and federal laws. We require updating this contract at a minimum of annually but it may be updated sooner depending on provider discretion.

1. I agree to give medication(s) to my child **ONLY** as prescribed. I will not change the dose or frequency unless discussed with my child's provider.
2. I agree not to share, sell, or otherwise dispense medication to anyone other than an authorized caregiver for patient (co-parent, acting guardian, school nurse, etc.).
3. I agree not to seek ADHD medicine from any other source to include other providers, emergency departments, urgent care, or other clinics.
4. I agree to call the office **immediately** if my child is experiencing any side effects from his/her medication(s).
5. I understand that I should check with my child's provider or pharmacist prior to taking other medications including over-the-counter medications and herbal substances.
6. I understand that my child may need to have other ADHD consultations, management strategies, or referrals as necessary to promote desired outcome. I will make every reasonable effort to comply with these measures.
7. I agree to have open communication between my doctor and any other health care professionals involved in my child's ADHD management such as pharmacists, other doctors/specialists, emergency departments, etc.
8. I understand that after initiation of treatment a 30-day follow is required. My child may be then seen monthly until optimum dose is achieved. After reaching therapeutic dose, a minimum of 90-day follow-up is required per federal government guidelines and office protocol.
9. I will keep my child's appointments and be respectful to all office staff. I understand that if I fail to show up at a scheduled ADHD/behavioral health appointment it will be considered a no show and rescheduled based on provider availability. There is a possibility medication(s) may not be prescribed until next appointment is kept.



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Controlled Substance Contract for ADHD continued

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10. I understand that I am responsible for safeguarding my child's supply of medication(s) against theft, loss, unauthorized use by others, etc. Early refills **will not** be given for stolen prescriptions/medications. If theft occurs a police report may be required.
11. I understand that refills need to be requested during regular business hours and with a 48-hour notice. I may do this during an office visit, in person, through patient portal, or by phone. It is important to make sure your child has enough medication to get through weekends, holidays, or after hours because after-hours and on call providers **will not** refill these.
12. If requesting a dose change, a follow-up may be required to review growth, blood pressure, blood work, etc.
13. Most ADHD medications can be sent electronically straight to the pharmacy but there may be instances when a prescription needs to be picked up in person. In those cases, a photo ID is required.
14. I understand that I may be asked to bring medication in for random pill counts and we check the CSMD (Controlled Substance Monitoring Database) for routine monitoring.
15. To promote well being and good health to all, I understand that should my child become pregnant or is combining alcohol, narcotics, or illicit drugs while taking ADHD medication(s) that I need to notify my provider immediately.
16. I understand that if I break this agreement then my provider reserves the right to stop prescribing for my child with possible dismissal from practice.

Parent/Guardian Signature: _____ Date: _____

Relationship to child: _____

Provider Signature: _____ Date: _____

_____ Parent/Guardian refuses to sign

Staff/Witness Signature for Refusal: _____ Date: _____

Staff/Witness Printed name: _____