** CONTROLLED SUBSTANCES AGREEMENT **

I, _____, a patient, or authorized consenting caregiver of a minor patient, of Treat-ADHD.com, PLLC, have been informed that individuals who are prescribed certain controlled substances including, but not limited to, stimulants, benzodiazepines, and barbiturate sedatives, can abuse those substances or may allow abuse by others, and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of the provider to consider prescribing or to continue prescribing controlled substances. This document is two pages, the rules are:

1. I will inform my provider of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.

2. I agree that I may be subject to a voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, while being prescribed controlled substances. I agree that the need to be evaluated by psychologists and/or psychiatrists is at the sole discretion of my provider at anytime during treat with controlled substances.

3. I will notify my provider immediately if another provider prescribes a controlled substance. This information is important to effectively provide care.

4. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform my provider at Treat-ADHD.com, PLLC and the next prescription will be available at the expiration date of the most recent prescription. In other words, a new prescription will not be issued until the 30-day current prescription is completed.

5. I will inform the Treat-ADHD.com, PLLC provider of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

6. I will inform my other health care providers that I am taking the controlled substances, and of the existence of this Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

7. I agree that my prescribing provider has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for accountability.

8. I will not allow anyone else to have, use, sell, or otherwise have access to these medications. The sharing of medications with anyone is absolutely forbidden and is against the law.

9. I understand that most controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially children, and I must keep them out of reach for safety.

10. I understand that tampering with a written prescription is a felony and I will not change or tamper with my provider's written prescription. Typically we prescribe electronically.

11. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

12. I agree not to alter my medication in any way, and I will take my medication whole, and it will not be broken, chewed, crushed, injected, or snorted.

13. I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by Todd Crawford, PMHNP-BC.

14. I understand that some drugs should not be stopped abruptly, as withdrawal syndromes may develop.

15. I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication by Todd Crawford, PMHNP-BC. Failure to comply may result in immediate discharge from the practice.

16. 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.

17. I understand that medications may not be replaced if they are lost, damaged, or stolen.

18. I understand that a prescription may be provided early if the physician or the patient will be out of town when the refill is due. These electronic prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.

19. If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration as required by law.

20. I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.

21. I understand that I may be asked to show my medications in their original container during the telehealth exam.

22. Refills will not be given over the phone/text, after office hours, and on holidays.

23. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my provider believes that the medication usage benefits me. I will comply with all treatments as outlined by Treat-ADHD.com, PLLC.

24. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and overdose.

25. I understand that failure to adhere to these policies and/or failure to comply with physician's treatment plan may result in cessation of therapy with controlled substance prescribing by this provider or referral for further specialty assessment, as well as possible discharge from the practice.

26. I, the undersigned patient or legal guardian, attest that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Agreement.

Signed_____ Date_____ Relationship to patient_____