Boynton Health Stimulant Agreement

This agreement allows us to work together in good faith, as partners in creating a safe and appropriate treatment plan for management of your attention-deficit/hyperactivity disorder (ADHD). If you are unable to adhere to the following treatment plan, Boynton Health may terminate prescription of stimulant medication.

Please initial next to the statements below.

I agree:

_____ I am taking a medication with potential harmful side effects. I have reviewed these side effects with my provider.
_____ I will obtain stimulant medication from one provider and will fill the medication at one pharmacy. I understand that I may not obtain stimulant medication from multiple sources.
_____ to take the medication exactly as prescribed and not change the medication dosage or frequency on my own.
_____ to keep my medication and prescriptions in a secure location. Lost, stolen, or misplaced prescriptions or medications will not be replaced.
_____ not to sell or share my medications. I understand to do so is a felony and that medication that is safe and effective for me can cause dangerous side effects for another person.
_____ early medication refills will generally not be authorized and medication extensions will not be granted when I am due for office follow-up. Disrespectful, aggressive, or threatening behavior when requesting medication refill is unacceptable.
_____ not to abuse alcohol or illegal drugs while taking this medication.
_____ to provide blood or urine drug screens and other diagnostic testing if clinically indicated in the judgment of the provider.
_____ to keep regular follow-up appointments as directed by the provider.
_____ my provider may decide to stop my stimulant medication due to other mental health or medical issues.
_____ stimulant medication may only partially treat my condition. I will participate in other referrals or treatments which my provider recommends for management of ADHD.

Name: _____ *Date of Birth:* _____
Signature: _____ *Date:* _____

Rev 9/25/13