Behavioral and Controlled Substance Agreement

Patient Name:
Patient DOB:

This agreement between you and your child's provider at Pediatric Associates is made in order for you to understand your personal responsibilities while your child is taking one or more of the following prescriptions: benzodiazepine and/or antipsychotic, stimulant medication, sleep medication, anti-depressant medication, and/or anti-anxiety medication. Please read the agreement fully and ask any questions that you have prior to signing.

I understand that Pediatric Associates will be monitoring my child's use and response to this medication(s). Additionally, my compliance with the following guidelines will be required:

1. My child will need to have ***scheduled visits to this office*** to safely monitor his or her medication(s). The number of visits required will depend upon my child's progress.

2. I will be required to ***give a 48-hour notice*** for medication refills. Due to unforeseen circumstances, if a prescription is unable to be electronically sent to the preferred pharmacy of my choice, I may be required to pick up my child's script during the following office hours: Monday-Thursday 8:00 a.m.-6:00 p.m., Friday 8:00 a.m.-5:00 p.m., Saturday 8:00 a.m.-12:00 p.m. Identification will be required when picking up my child's prescription. If I am unable to pick up my child's prescription, I will contact Pediatric Associates to complete a "guardian consent form".

3. I understand that I am responsible to **notify my child's provider of any changes** to my address and phone number.

4. If my child is **experiencing any side effect(s)** from his or her medication(s), I will **call the office immediately.**

5. If I request a dosage change for my child I will call the office. A review of my child's growth, blood pressure, blood work, may be necessary.

6. I understand that **I am responsible for my child taking medication(s) as prescribed** and I am not allowed to request new prescriptions before they are due. Exceptions will be made for parents that use mail order pharmacies.

7. I understand that **I am responsible for safeguarding my child's supply of medication** (against theft, loss, unauthorized use by others, etc.) and will not receive early refills of my prescriptions. If theft occurs, information from the police report is required.

8. I will **not request medication for my child from after-hours "on call" physicians or other practitioners including dentists and emergency department personnel**. All medication requests will be made at the time of a scheduled appointment or by phone during regular business hours.

9. I authorize Pediatric Associates to contact and release a copy of this agreement to pharmacies, dentists and other medical practitioners involved with my child's medical care for the purpose of monitoring my child's prescription medication use, and give further consent to local emergency room department, pharmacies, dentists, and other practitioners responsible for my child's medical care to report violations of the agreement to Pediatric Associates. I further give consent to Pediatric Associates to contact and release information regarding my child's controlled substance(s) use to appropriate law enforcement authorities if they become concerned that I or my child have been involved in illegal activity pertaining to my child's use of a controlled substance.

10. I understand that controlled substance medication (s) is only part of my child's treatment. I know that there are **other aspects of my child's treatment (for example, counseling, various behavioral modification techniques and additional testing)** that my child may be required to perform or participate in while he/she is taking prescribed controlled substance. The decision as to whether the medication is providing sufficient therapeutic benefit to justify continued use is a medical determination that will be made only by my child's Pediatric Associates provider.

11. I will **keep my child's behavioral and physical appointments as scheduled**. I will contact Pediatric Associates as soon as possible in the event I need to cancel or reschedule an appointment. If I fail to show up at the time of a scheduled appointment it will be recorded in my child's chart as a "**no show**". When missing or rescheduling an appointment, there is the possibility that **medications may not be refilled or prescribed until the next appointment is kept**. The third time I miss or reschedule my child's behavioral appointment at the last minute ***I will be asked to transfer my child to a different behavioral healthcare provider in the community.***

12. All patients who are prescribed behavioral medications may be subject to a random urine drug screening a minimum of twice a year and the patient's health insurance will be billed for the cost of the drug screening.

13. If requested, **I agree to comply with a random pill count**, which will require me to bring the patient's medication to the office within 24 hours to have one of Pediatric Associates staff members count the number of pills that the patient has left until his/her next refill. I understand that if I fail to comply with having the patient's pills counted, the patient's medication may not be refilled by Pediatric Associates.

14. Pediatric Associates may ask for the patient to **return any discontinued patient medications to the office for appropriate and lawful disposal.**

15. I **agree to comply with the foregoing guidelines** as a condition to the provision of services to my child by the practice. I understand that any violation of the above guidelines or requirements may result in my child's controlled medication prescription not being refilled and my discharge from the practice.

Revised on 01/17/2023

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I ____agree to the above guidelines
(Guardian's Printed Name)

regarding the treatment of Patient Name: _______________________ and DOB:________________.

Signature of Guardian: ____
Relationship to Patient:_____________________________________
Date:_________________________