PONDWORKS
PSYCHIATRY AND PSYCHOTHERAPY

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# PONDWORKS PATIENT AGREEMENT FOR PSYCHOSTIMULANT THERAPY

Name: _____ Date: _____

1. I agree that _____ (provider's name) will be the only provider prescribing psychostimulant therapy for me.

2. I understand the importance of taking the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of the medication without first discussing it with my provider. I understand that expected prescription refill dates will be used to promote optimal use of this medication.

3. I will attend all appointments, treatments and consultations as requested by my provider.

4. I will attend annual well visits with a primary care physician, and additional visits if requested by my provider.

5. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. I acknowledge that my provider is not obligated to replace any medication shortfall.

6. I consent to open communication between my provider and any other health care professionals involved in my ADHD management.

7. I understand that, if I break this agreement, my provider reserves the right to stop prescribing stimulant medications for me.

_____
Patient Signature