Stimulant Medication Treatment Agreement

Name: ___________________________________

Date of Birth: _____________________________

Your doctor has decided to initiate/continue treatment with a stimulant medication. This group of medications are highly regulated by the DEA and are classified under Schedule IIN. Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence. As such, close monitoring during treatment is necessary to ensure appropriate use of these medications. By signing this document, you agree to abide by the following clinic rules:

- Medication must be taken as prescribed.
- Prescription will be written only after an appointment.
- Consistent attendance of appointments is required.
- Refill requests without an appointment will not be accepted.
- Early refills will not be accepted.
- A max of 30-day supply will be prescribed with each appointment.
- Prescription Drug Monitoring Program (PDMP) will be checked at each refill.
- Occasionally, urine drug screens will be required.

Signature: _____________________________________ Date: _________________________