altheda
MEDICAL CENTER

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Patient Agreement for Stimulant Medication Prescriptions

This agreement explains Altheda Medical Center's policy for prescribing stimulant medications (such as Adderall, Vyvanse, Concerta, and related medications). Because these are controlled substances with a high potential for misuse, strict rules are in place. Your signature is required to confirm you understand and agree to these policies.

Policy Summary:

1. I must be seen by a psychiatric provider at Altheda **at least once every 30 days (1 month)** *unless stated otherwise by my psychiatric provider*.
2. ***No stimulant refills will be provided if I have not attended a follow-up appointment within 30 days.*** 3. Refill requests made late or after missing an appointment will not be granted.
4. **"Bridge" prescriptions will only be considered in rare emergencies** (e.g., provider cancellation or documented personal emergency).
5. Lost or stolen medications will not be replaced.
6. I will schedule my next follow-up before leaving each appointment or when I have **at least 2 weeks of medication left**.
7. I agree to use one pharmacy and notify Altheda of any changes in a timely manner.
8. I understand that Altheda may check the Prescription Drug Monitoring Program (PDMP) and request drug screening if necessary.

Patient Responsibilities:
I understand that it is my responsibility to:

1. Keep track of my medication supply.
2. Schedule follow-up appointments in advance.
3. Take my medication as prescribed.
4. Notify my provider of any side effects, concerns, or changes in my condition
5. Follow all federal, state, and Altheda Medical Center rules regarding controlled substances.

Consequences of Non-Compliance:
If I do not follow these rules, Altheda Medical Center may:

1. Refuse to provide refills until I am seen in an appointment.
2. Discontinue prescribing stimulant medications to me.
3. Terminate my controlled substance agreement with Altheda.

Acknowledgement & Signature:
By signing below, I acknowledge that I have read, understand, and agree to comply with the stimulant prescription policy at Altheda Medical Center.

Patient Name: _____

Patient Signature: _____ Date: _____