TRANSCULTURAL CARE ADHD TREATMENT AGREEMENT

Transcultural Care
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I, _____, UNDERSTAND AND AGREE TO THE FOLLOWING CONDITIONS REGARDING ADHD TREATMENT WITH TRANSCULTURAL CARE, LLC:

1. An initial evaluation will be completed to review all symptoms, medications, medical and family history. I am aware that psychological testing may be deemed necessary for some patients along with ADHD screening scales that may warrant completion by the patient or outside sources. I understand that this evaluation does not guarantee a diagnosis of ADHD, nor will there be a prescription written until all studies listed below are completed. A determination will be made and discussed during the evaluation.

2. I understand that if risk factors are identified, an electrocardiogram (EKG) or cardiac consult may be indicated to determine a baseline for overall heart function. This may need to be performed annually based on the initial results and/or an as needed basis. Some patients will need to complete these tests and consultations prior to starting medications.

3. All follow up appointments scheduled must be attended, and medication refills cannot be obtained without an appointment or approval from the provider. Replacement prescriptions will not be given for lost or stolen scripts, and the patient must have a follow up appointment. If medications are stolen, a police report must be filed and returned to the office to be included in the file.

4. Urine drug screen will be required from time to time.

5. The Mississippi Prescription Monitoring Program (PMP) is assessed prior to initial evaluation and at each visit, to verify prescriptive history. Medication for ADHD can only be obtained from a single provider. Refills can only be written for 30 days at a time. Refills beyond a 30 day supply will be dated for the earliest fill date.

6. If currently prescribed benzodiazepines, it is the policy of the practice that assistance may be provided (at the discretion of the provider) in tapering off these medications with the option of substituting with the other non-addictive/non benzo type medications. This will be further discussed during the appointment.

By signing below, I indicated that I agree with all of the terms set forth above

Patient Signature: _____Print Name: _____ Date_____

Parent Signature: (if patient is a minor) _____ Print Name_____ Date_____