pediatric associates • north shore

helping families thrive

PSYCHOACTIVE MEDICATION TREATMENT AGREEMENT

Patient Name _____ Date of Birth _____

TREATMENT PLAN

In order to have PANS supervise and prescribe psychoactive medications (including those used to treat ADHD, depression, anxiety, etc), I understand that my child must have a yearly well child visit,and medication follow-up appointments as directed by the physician. These follow-up appointments will occur at least once every three months once a stable dose is reached but may be more frequent when starting a medication or adjusting doses. A medication follow-up visit may be combined with an annual well visit only if this is requested at the time of the scheduling. I understand that behavioral/mental health care cannot be combined with a sick visit.

CONTROLLED SUBSTANCES

I understand that ADHD stimulant medications are classified as controlled substances by the FDA and are monitored by the DEA. These prescriptions can only be electronically prescribed as a 1 month supply and only for 3 months at a time. The 'fill dates' for future prescriptions are available in the electronic medical record. By law, these medications cannot be automatically refilled and cannot be phoned to a pharmacy.

PRESCRIPTIONS

I understand that requests for refill prescriptions must be requested via the patient portal (MyChart) at least five days before the completion of my child's medication supply.

PRIOR AUTHORIZATIONS

I understand that my insurance company may require a prior authorization which could delay the filling of my child's prescription. Please allow our office three business days to process these requests.

REQUIRED FOLLOW-UP

I understand that my child will need a medication follow-up appointment at least 5 days before the completion of their medication supply. I understand that the physician will monitor my child's symptoms and side effects using assessment questionnaires which must be completed in the patient portal before arriving for the visit. Additional prescriptions may not be issued until the medication follow-up appointment is completed.

FAILURE TO COMPLY

I understand that if I/we fail to comply with this agreement, the physician may discontinue medication and/or treatment.

PHYSICIAN DISCRETION

Any of the policies listed above - except for those required by law - may be altered with proper notice by the primary care physician.

Signature of Guardian/Parent _____ Date Signed _____

Printed Name of Guardian/Parent _____