Mid Cities Psychiatry

# Medication Acknowledgement for ADD

By signing this agreement, I, _____ I agree to the following:
(patient's printed name)

1. To see my psychiatrist every month for my prescription for ADD.
2. To have Urine Drug Screen randomly at the office of Mid Cities Psychiatry. If Urine Drug Screen is positive for any substances, the ADD prescription may be declined.
3. To have EKG done every year by primary care physician for ADD medication and have results present/faxed to Mid Cities Psychiatry.
4. To have a physical examination yearly by my Primary Care Physician for ADD medication.
5. To pay all office fees at the time of my visits for random Urine Drug Screen at the office of Mid Cities Psychiatry before the prescription is dispensed.

_____ _____

Signature of Patient or Responsible Party (if minor Patient) Date

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