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 provide a urine sample upon request for a Urine Drug Screen, either at the office of Mid Cities Psychiatry or through an accredited laboratory within 48 hours of Mid Cities Psychiatry's request. If the Urine Drug Screen is (1) positive for substances not prescribed or (2) negative for medications prescribed by a medical professional engaged in my care and treatment, Mid Cities Psychiatry has the right to decline any further ADD prescriptions.
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 before the service/prescription is rendered.

_____ _____

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

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