Madison Pediatric Associates

Patient Responsibility Agreement for Controlled Substance Prescriptions

Controlled substances (i.e. ADHD medications) can be very useful in managing certain medical conditions. However, due to their potential for misuse, these medications are closely regulated by local, state, and federal authorities. Because my child is being prescribed a controlled substance by their physician, I understand and agree with the following conditions:

1. Responsibility for Medications: I am fully responsible for all controlled substance medications prescribed to my child. Lost, stolen, or misplaced prescriptions, or requests for early refills, will **not** be replaced or refilled under any circumstances.

2. Refill Policy: Refills for controlled substances will only be processed during regular business hours: **Monday–Friday, 9:00 AM to 5:00 PM.** No refills will be issued during evenings, weekends, or holidays. The prescription must be signed by my child's treating physician. Therefore, I understand that **at least one week's notice** is required for all refill requests.

3. Regular Follow-Up Appointments: My child must be seen for a **medication re-check at least once every three (3) months.** Failure to comply with this requirement will result in Madison Pediatric Associates discontinuing prescription refills.

4. Random Drug Testing: I agree that my child may be selected to submit to **random urine drug screening** to verify proper use of the medication and ensure treatment compliance.

5. Misuse and Reporting: I understand that **improper use of the medication**, including taking it in a way not prescribed or giving it to anyone else, may be reported to my child's physician, other healthcare providers, or appropriate authorities.

6. Identification Requirement: I understand that I may be required to present **a valid photo ID** when picking up my child's prescription.

7. Violation of Agreement: I understand that **any violation** of the terms outlined in this agreement may result in **immediate discontinuation** of controlled substance prescriptions for my child.

I have read and fully understand the terms of this agreement. These terms have been explained to me by Madison Pediatric Associates, and I accept the responsibilities described above. I understand the consequences of non-compliance with this agreement.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

If you would like more information regarding KASPER, please visit: http://chrs.ky.gov