BRIGHT STAR
Child and Adolescent Psychiatry

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Medication Agreement

As part of your child's treatment, Bright Star Child & Adolescent Psychiatry's licensed providers may prescribe medications for your child. These medications possibly could have serious side effects if they are not managed properly. Your child's health and safety are very important to us, and we need your help to make sure safe guidelines are followed.

If our staff has questions regarding your child's healthcare, privacy laws allow us to contact your other treating providers and pharmacies.

1. I agree to follow the dosing schedule prescribed to me by my healthcare provider.
2. I agree to never share my child's medications with others, nor will I sell or exchange my medications for any reason.
3. I understand there will be no early refills of controlled substances.
4. I understand medication refill requests should be called in a week in advance and during business hours on Tuesday, Wednesday, or Thursday and requests should not be left on the answering machine.
5. I agree to keep all scheduled appointments. I understand that no medications will be given following cancelled or rescheduled appointments or following appointments that are missed. I understand that if I am more than 10 minutes late to my scheduled appointment, I may have to reschedule and may be charged a fee.
6. I understand that some medications may cause drowsiness or impaired cognitive function and physical activities should be avoided by my child when motor coordination is impaired.
7. I understand that abusive behavior or harassment toward staff will not be tolerated and result in my child's dismissal from the practice.
8. I understand that dealing with a forged or falsified prescription will result in my child's immediate dismissal.
9. I understand that our medical providers may request a urine drug screen at any time when controlled substances are prescribed. The absence or presence of certain controlled substances may result in my child's dismissal from the practice.
10. I understand that my child may be dismissed from the practice if I do not abide by the terms of this medication agreement.

I agree that I will be bound by this agreement and that I have read, understood, and accepted these terms. No medications will be prescribed without the acceptance of this agreement.

Patient name	Date of birth
Patient guardian signature	Date