PONDWORKS
PSYCHIATRY AND PSYCHOTHERAPY

3636 Executive Center Dr., Ste. G-70, Austin, TX 78731
Front Office: (512) 420-2224, Main Number: (512) 371-9555, Option 3: provider menu

PONDWORKS PATIENT AGREEMENT FOR PSYCHOSTIMULANT THERAPY

Name: _____ Date: _____

1. I agree that _Bernard Kim, MD_ (provider's name) will be the only provider prescribing psychostimulant therapy for me.

2. I understand the importance of taking the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of the medication without first discussing it with my provider. I understand that expected prescription refill dates will be used to promote optimal use of this medication.

3. I will attend all appointments, treatments and consultations as requested by my provider.

4. I will attend annual well visits with a primary care physician, and additional visits if requested by my provider. I understand that this is a requirement for prescribing.

5. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. I acknowledge that my provider is not obligated to replace any medication shortfall.

6. I consent to open communication between my provider and any other health care professionals involved in my ADHD management.

7. I understand that, if I break this agreement, my provider reserves the right to stop prescribing stimulant medications for me.

8. If I need to reach my provider between appointments, I agree to leave a confidential voice mail for my provider at 512-371-9555, Option 3.

This electronic agreement will have the same force and effect for purposes of validity, enforceability and admissibility as an originally executed signature.

_____
Patient Signature