"It's okay to not be okay."

iMind Mental Health and Wellness Controlled Substance Agreement
&
Informed Consent

The contract below is intended to promote a mutual understanding between the provider and the patient regarding controlled/scheduled medications. A controlled/scheduled substance is intended to decrease specific symptoms and may affect mood, behavior or has the potential for dependence or tolerance.
The providers of iMind Mental Health and Wellness define controlled/controlled substance abuse as the following:

- Repeatedly requesting early refills on controlled/scheduled substances.
- Receiving multiple controlled substance prescriptions from different providers.
- Altering written prescriptions.
- Selling controlled/scheduled substances.
- Sharing controlled/scheduled substances with others (including family members).
- Using controlled/scheduled substances other than as prescribed.

I understand that I have the following responsibilities:

1. I will take the medications at the dose and frequency prescribed.
2. I will obtain all refills for controlled/scheduled medication(s) at the pharmacy listed below.
3. I will protect my controlled/scheduled medications and I understand that it is my responsibility to keep all medications safe and secure. I understand that lost, stolen, or misplaced prescriptions will not be replaced unless a police report is filed.
4. I will keep medications solely for my own use and will not sell, lend, share or give any of my controlled/scheduled medication(s) to others. Failure to uphold this term may constitute a criminal offense.
5. I agree to comply with all components of my overall treatment plan including medical, psychological or psychiatric assessments as recommended by the provider.
6. I will not use illegal street drugs or another person's prescription medication. I will not use alcohol or other sedating medications without discussing with provider first.
7. I will consent to unannounced drug screenings which may include:
   a. Providing a urine or blood sample.
   b. Providing prescription containers with remaining doses for medication count to determine appropriate usage.
   c. Any refusal to participate in the unannounced drug screening will result in an automatic failure of the drug screening. I understand that I may still be seen by the appropriate provider, but that no controlled substance will be prescribed.
8. I understand that the provider will monitor the tri-state prescription monitoring database to monitor any other controlled/scheduled substances I may receive.
9. I will keep all scheduled appointments.

I understand if I violate one or more of the terms listed above, the agreement will become null and void. The medication regime will be stopped, and I may be dismissed as a patient from iMind Mental Health and Wellness.
_____ Patient Initials

The pharmacy that I will use to fill my prescription is:

_____ Phone: _____

By signing this contract, I signify my understanding and agree to adhere to its terms.

_____ _____
Patient Signature **Date**

_____ _____
Provider Signature **Date**