CONTROLLED SUBSTANCE TREATMENT AGREEMENT

The purpose of this agreement is to set out the rules and regulations that are enforced at all CIMG clinics for any of our providers to prescribe controlled substances. These apply to all patients who are prescribed controlled medications by any of our providers in an ongoing basis. These rules and regulations are meant to assure that such medications are prescribed in a safe and responsible manner and in accordance with all government regulatory agencies. Please initial each line to indicate that you have understood each rule.

__________I understand that the medicine prescribed to my child is a controlled substance that requires close monitoring.

__________I understand that while under the care of a CIMG provider I will not obtain nor seek from another healthcare provider any controlled substance for my child.
I understand that I will not borrow, lend, sell nor trade control substances that were prescribed to my child.

__________I understand that I will faithfully and strictly follow the instructions of the prescribed controlled substance.

__________I understand that I must and will safeguard the prescribed controlled substance and I understand that lost, misplaced or stolen medications will not be replaced until the appropriate refill date.

__________I agree for my child to be randomly tested (urine or hair) to assure my compliance of treatment plan.

__________I understand that if I choose not to follow the prescribed treatment plan without discussing it with my child's healthcare provider, I am being negligent and such action could/will be reported to the appropriate authorities.

__________I understand that my child's-controlled substance will only be prescribed during an in clinic or telehealth visit.

_________ I understand that **failure to show up** to my child in clinic or telehealth appointment could/will result on been discharged from CIMG.

__________I understand that I can only request refills of controlled substances medication during an office visit (face-to-face) on a monthly basis, unless otherwise stated by the servicing provider.

__________I understand that a violation of any of the above rules will constitute a total violation of this agreement which could be a cause for my child/children to be discharged from all CIMG's providers and clinics.

__________I understand that these rules and the agreement are not judgmental and that the intent is to collaborate with my provider to create the best treatment plan for my child. Failure to follow these rules does not mean that I am abusing or misusing the prescribed controlled medications, but it means that the CIMG healthcare provider will not be able to prescribe controlled substances even if the infraction was unintended and/or innocent.

Patient's Name: ____

DOB: ____

Parent's Name: ____

Parent's Signature: ____

Date: ____

CIMG Witness: ____