

Buprenorphine Treatment Agreement

I _____ am requesting that my doctor provide buprenorphine treatment for opioid addiction. I freely and voluntarily agree to accept this treatment agreement, as follows:

____ (1) I agree to keep and be on time to all my scheduled appointments.

____ (2) I agree to adhere to the payment policy outlined by this office.

____ (3) I agree to conduct myself in a courteous manner in the doctor's office.

____ (4) I agree to be honest and notify the doctor of all medications I am taking.

____ (5) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me and I will not be given any medication until my next scheduled appointment. Urine drug screens will be random.

____ (6) I agree not to sell, share or give any of my medication to another person. I understand that such mishandling of my medications is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

____ (7) I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to this office and could result in my treatment being terminated without recourse for appeal.

____ (8) I agree that my medication/ prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/ prescription until my next scheduled visit.

____ (9) I understand that the use of buprenorphine/naloxone (Suboxone) by someone who is addicted to opioids could cause them to experience severe withdrawal. Stopping buprenorphine in itself can cause opiate withdrawals.

____ (10) I agree not to deal, steal, or conduct any other illegal or disruptive activities in or in the vicinity of the doctor's office.

____ (11) I agree that the medication I receive is my responsibility and that I will keep safe, secure place. I agree that lost medication will not be replace regardless of the reasons for such loss.

____ (12) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications especially benzodiazepines, such as Valium, Xanax, Ativan, and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses)

____ (13) I agree to take my medication as the doctor, and his/her assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.

_____ (14) I understand that medication alone is not sufficient treatment for my condition. Therefore, I agree to participate in one or more of the following: One on one counseling with a therapist, enroll in the "Here to Help" program (This is a free program) and Alcoholics Anonymous/Narcotics Anonymous/ect, groups to develop a sober support fellowship in the community. A resource list will be provided to assist you in your information package.

_____ (15) I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine)

_____ (16) I understand that mishandling of my medications is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

_____ (17) I understand that mixing buprenorphine with other medications, especially benzodiazepines such as Valium, Xanax, Ativan can be dangerous. I also recognize that several of deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses)

_____ (18) I agree to take my medications as Dr. Mosby has instructed and not to alter the way I take my medication without first consulting with him.

I understand that my buprenorphine treatment may be discontinued and I may be discharged from the clinic if I violate any of this agreement.

I have read and understand the details about Buprenorphine treatment. I wish to be treated with Buprenorphine.

Patient's Signature _____ **Date** _____