

BUPRENORPHINE/NALOXONE TREATMENT AGREEMENT

Patient Name:

MR#:

I am requesting this office provide buprenorphine/naloxone treatment for opioid
_____ addiction. I freely and voluntarily agree to accept this treatment
list drug(s)
agreement, as follows:

- (1) I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.
- (2) I agree to conduct myself in a courteous manner in the Physician's or NP's office.
- (3) I agree to pay all office fees for this treatment at the time of my visits. I will be given a receipt that I can use to get reimbursement from my insurance company if this treatment is a covered service. I understand that this medication has costs in addition to the office visits and counseling visits required.
- (4) 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.
- (5) I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.
- (6) I understand that the use of buprenorphine/naloxone by someone who is addicted to opioids could cause them to experience severe withdrawal.
- (7) I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of the doctor's office or anywhere else.
- (8) I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit. I FURTHER AGREE TO USE ONE PHARMACY ONLY , UNLESS ARRANGEMENTS ARE MADE THROUGH THIS PROVIDER.
- (9) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.
- (10) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing my treating provider. I understand that mixing buprenorphine/naloxone with other medications, especially benzodiazepines (sedatives or tranquilizers), such as Valium (diazepam), Xanax (alprazolam), Librium (chlordiazepoxide), Ativan (lorazepam), and/or other drugs of abuse including alcohol, can be dangerous. I also understand that a number of deaths have been reported in persons mixing buprenorphine with benzodiazepines. I also understand that I should not drink alcohol while taking this medication as the combination could

produce excessive sedation or impaired thinking or other medically dangerous events.

- (11) I agree to take my medication only as the provider has instructed, and not to alter the way I take my medication without first consulting the doctor.
- (12) I understand that medication alone is not sufficient treatment for my disease and I agree to participate in psychotherapy individual and/or group patient education and relapse prevention to assist me in my recovery.
- (13) I understand that my buprenorphine/naloxone treatment may be discontinued and I may be discharged from the clinic if I violate this agreement.
- (14) I understand that there are alternatives to buprenorphine/naloxone treatment for opioid addiction including:
 - a. medical withdrawal and drug-free treatment
 - b. naltrexone treatment
 - c. methadone treatment

Any deception discovered is grounds for termination of this agreement.

* I UNDERSTAND THAT I WILL BE SUBJECT TO ROUTINE AND RANDON URINE DRUG SCREENS AS PART OF THIS PROGRAM...
IN THE EVENT I AM CALLED IN TO THE OFFICE FOR A SCREEN OR A RANDOM PILL/FILM COUNT, I AGREE TO COMPLY WITHIN THE TIME FRAME STIPULATED FOR RESPONSE, OR I MAY BE SUBJECT TO DISCHARGE FROM THE PRACTICE.

Patient's Signature

Date

Witness Signature

Date