Revised 9-25-10

BUPRENORPHINE/NALOXONE TREATMENT AGREEMENT

Patient Name: **MR#:**

I am requesting that my doctor 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 clinic'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 will cost between $5-$10 a day just for medication and that the office visits are a separate charge.

(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.

(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 physician. 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 as the doctor 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 the recommended patient education and relapse prevention program, 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

My doctor will discuss these with me and provide a referral if I request this.

_____ _____

Patient's Signature Date

_____ _____

Witness Signature Date

☐ Yes	☐ No	**19.** I agree that a network of support, and communication among persons in that network, is an important part of my recovery. I will be asked for my authorization, to allow telephone, email, or face-to-face contact, as appropriate, between my treatment team, and outside parties, including physicians, therapists, probation and parole officers, and other parties, when the staff has decided that open communication about my case, on my behalf, is necessary.
☐ Yes	☐ No	**20.** I agree that I will be open and honest with my counselors and inform staff about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which *has* occurred --*before* a drug test result shows it.
☐ Yes	☐ No	**21.** I have been given a copy of clinic procedures, including hours of operation, the clinic phone number, and responsibilities to me as a recipient of addiction treatment services, including buprenorphine treatment with Buprenorphine/naloxone.

Patient Signature:_____ Date:_____

Staff Signature/Title:_____ Date:_____