

APPENDIX 4

BUPRENORPHINE TREATMENT AGREEMENT/CONTRACT

As a participant in the buprenorphine protocol for treatment of opioid abuse and dependence, I freely and voluntarily agree to accept this treatment agreement/contract, as follows:

- I agree to keep, and be on time to, all my scheduled appointments with the doctor and his/her assistant.
- I agree to attend substance abuse counseling at least weekly; more often at the initiation of treatment.
- I understand that urine collections will be performed to send for drug screens.
- I agree to conduct myself in a courteous manner in the physician's office.
- I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.
- I agree not to sell, share, or give any of my medication to another individual. 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.
- I agree not to deal, steal, or conduct any other illegal or disruptive activities in the doctor's office.
- I agree that my medication (or prescriptions) can be given to me only 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 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.
- I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as valium and other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines.
- 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.
- I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist me in my treatment.
- I understand that I may be transitioned to Suboxone (buprenorphine/naloxone) following delivery (exception: breastfeeding and baby in treatment).

PATIENT SIGNATURE

PRINTED NAME