

Name/Practice Name: _____
Address: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Fax: _____

PATIENT TREATMENT CONTRACT

Patient Name: _____ **Date:** _____

As a participant in medication treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract 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 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 any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. 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 medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. 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 the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium^{®*}, Klonopin^{®†}, or Xanax^{®†}), can be dangerous. I also recognize that several 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).
11. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.
12. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

14. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).
15. I agree to provide random urine samples and have my doctor test my blood alcohol level.
16. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature

Date

*Valium® is a registered trademark of Roche Products Inc.

†Klonopin® is a registered trademark of Roche Laboratories Inc.

‡Xanax® is a registered trademark of Pharmacia & Upjohn Company.