Medication Assisted Treatment Patient Contract

Suboxone (due to common usage, the term Suboxone will be used for all combined buprenorphine/naloxone products) & buprenorphine are used to help people treat opioid use disorder successfully participate in medication assisted treatment therapy, which includes buprenorphine containing products. In order to receive Suboxone and/or buprenorphine from any Tri-Rivers Healthcare facility, you must fully agree to this Treatment Contract and place your initials next to each item and sign this Treatment Contract.

Your initials mean you have read, understand, and acknowledge what is said in the paragraph next to your initials, and if the paragraph calls for an agreement from you, your initials indicate agreement to accept responsibility for the terms of this contract throughout your Medication Assisted Treatment. Failure to abide by any of these requirements/agreements may result in your discharge from the Treatment Program without recourse or appeal.

1. _____ **Information regarding Suboxone and/or buprenorphine therapy.** My Provider has discussed with me various options for treatment of my opioid disorder, including non-pharmacological options. My Provider has explained, and I understand, the risks and benefits of buprenorphine, including potential side effects. I understand that in order to be a satisfactory candidate for Suboxone/buprenorphine I must follow certain safety precautions for the treatment and comply with the treatment schedule prepared for me by my Provider. This includes recommended lab tests, which will typically be liver tests every 6 months and may include recommendations on screening for hepatitis and HIV. Additionally, my Provider and staff have discussed this agreement with me and explained what is expected of me in the program. Having taken all of this information into account, I desire to enter into MAT and agree to comply with the requirements described herein.

2. _____ **Attendance at all scheduled appointments.** I agree to keep and be on time for all of my scheduled appointments. After induction and establishment when the appropriate Suboxone dose has been achieved, appointments will be scheduled on a 28-to-30-day rotation as deemed appropriate by my Provider. Missed and rescheduled appointments will require a drug screen within 24 hours. I understand that "No Show" and/or repeated cancelled appointments will be considered positive drug screens and may be grounds for discharge from the MAT program. I understand that if I miss an appointment and did not notify the clinic in advance to cancel my appointment, I will be dismissed from the MAT Program and I will not be given any refills for my medication. If I miss or reschedule an appointment for a later date, I understand that my medications will not be refilled until the time of my next scheduled appointment with my MAT provider. I understand all appointment changes will be handled by the Program Coordinator; I will ask to talk to them if appointment changes are needed.

3. _____ **Induction transportation.** I agree that I will not drive a motor vehicle or use power tools or other dangerous machinery during my first days of taking

Suboxone/Buprenorphine, to make sure that I can tolerate taking it without becoming sleepy or clumsy as a side-effect of taking it. I also agree to arrange transportation to and from the MAT Clinic during my first days of taking Suboxone, so I am not required to drive myself during this time, thus reducing the danger to myself and other bystanders.

4. _____ **Walk-in visits.** I understand that Suboxone can only be prescribed by a specially licensed provider. I can only get Suboxone refills during scheduled office visits with my MAT Provider and I will not be able to obtain Suboxone/buprenorphine refills during walk-in visits, after regular clinic hours, on weekends, or holidays. I will always bring my appointment card to my appointments. If my appointment was not scheduled at the fault of the Clinic, the only way I will be seen is by having my appointment card as proof. I will make sure that I pick up my new appointment card form the Receptionist and confirm the appointment prior to leaving the Clinic. **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.**

5. _____ **MAT Conduct Policy.** I agree to conduct myself in a courteous manner while in the MAT Clinic as well as any other place of business associated with the clinic including but not limited to my Pharmacy of choice or any treatment center or therapy group, I may attend in accordance with my agreed upon treatment plan. Once I have asked a question and received an answer or told an answer is pending per what my Provider prefers, I will not badger, continue to call, or become a nuisance to any person involved in my treatment plan. Any adverse behavior (including but not limited to that mentioned above) that may be deemed detrimental to my treatment plan and clinic staff, may be cause for my discharge from the practice.

6. _____ **Abuse of any persons involved in my MAT Treatment.** I will refrain from any verbal or physical abuse to any clinic, pharmacy, or drug testing facility staff member or any person involved in my treatment plan. Any reported abuse by me may result in my discharge from the practice with no recourse or appeal.

7. _____ **Arrival at any Tri-Rivers Healthcare clinic under the influence.** I agree not to arrive at the clinic or any facility involved in my MAT treatment while intoxicated or under the influence of any alcohol, prescription medications not prescribed in my name, or any street drugs that are in and of themselves illegal to use, possess, or distribute. My arrival in this state will result in not being seen by my Provider and not getting my medication refilled until my next scheduled appointment, or complete discharge from the practice without recourse or appeal.

8. _____ **Illegal activities while in or around any facility associated with my MAT treatment.** I agree not to deal, steal, or conduct any illegal or disruptive activities in the Clinic, the pharmacy where my prescription is filled, or any other facility involved in my MAT treatment. Any observed or suspected behavior of this sort will be reported to my Provider and may result in my discharge from the practice without recourse or appeal.

9. _____ **Selling or sharing Suboxone/Buprenorphine.** I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication or alteration/forgoing of the prescription is a serious violation of this agreement and will result in my immediate discharge from the practice without recourse or appeal.

10. _____ **Theft of my Suboxone.** I understand that Suboxone is a powerful drug. People who want to get high or sell Suboxone for a profit may want to steal my take-home prescription supplies. My medication must be protected from theft or unauthorized use.

If my medications are stolen, I will file a Police Report and bring a copy to my next appointment, fully understanding that my medication/prescription may not be refilled until my next scheduled appointment, thus resulting in the increased chances of experiencing opiate withdrawal symptoms if I run out of my medication.

11. _____ **Loss of Suboxone.** I will be careful with my take-home prescription supplies of Suboxone and agree that I have been informed that if I report that my supplies have been lost or stolen, that my Provider will not be requested or expected to provide me with make-up supplies. This means that if I run out of my medication supplies it could result in my experiencing symptoms of opioid withdrawal.

12. _____ **Suboxone storage and accidental ingestion.** I have a means to store take-home prescription supplies of Suboxone safely, where it cannot be taken accidentally by children or pets or stolen by unauthorized users. I agree that if my Suboxone tablets/films are taken by anyone besides me, I will call 911 and the Poison Control Hotline at 1-800-222-1222 immediately and see that the Person is transported to the nearest appropriate medical facility for treatment.

13. _____ **Pill Counts.** I understand that in order to ensure that I am taking my Suboxone as prescribed, I will bring my remaining Suboxone to each appointment for a count to be sure that I have the appropriate amount remaining. My Provider may also call me at random, requesting that I give him a verbal pill count at that time. I may also be required to present to the clinic within 24 hours of notification for a count of my medication strips or tabs. In the case that there is a message left on my voice mail I only have 24 hours to respond, or it will be grounds for my discharge from the MAT program.

14. _____ **Take as prescribed.** I understand that the use of Suboxone in a manner other an as prescribed may be dangerous to my health. I will take my Suboxone exactly as it is prescribed and shall comply with the directions of my Provider for its use. I will not adjust the dosage myself. If I feel that the dosage of Suboxone prescribed to me is not working correctly, I will contact my Provider to discuss changes, or if necessary, schedule an appointment to discuss potential alterations in the dosage.

15. _____ **Abstinence from alcohol and drugs.** I understand that in order for my participation in the MAT treatment to be meaningful, and in order to promote my health and

safety, it is necessary to agree to and actually abstain from drinking alcohol or taking drugs that have not been prescribed to me. I also understand and have been made aware that mixing Suboxone with other medications, especially benzodiazepines (including but not limited to Diazepam [Valium], Clonazepam [Klonopin], Alprazolam [Xanax], Lorazepam [Ativan], Chlordiazepoxide [Librium], Oxazepam [Serax], can be dangerous and has been associated with severe adverse events including: ACCIDENTAL OVERDOSE, OVER-SEDATION, COMA, OR DEATH. The use of alcohol with Suboxone can produce Decreased Respirations, Impaired Thinking, or Impaired Behavior.

16. _____ **Other prescription medications.** I agree to inform my MAT Provider and all other medical care providers I am seeing of all medications that I am taking including over-the-counter supplements. I understand this is important for my safety and to assure that another medication is not prescribed which may lead to harmful side-effects. I will report **any** new prescriptions given to me by **any** other provider, Dentist, Dermatologist, Psychiatrist, Pharmacy, or **any** other sources etc. to my MAT treatment Provider so she can assess then for adverse interactions with my Suboxone.

17. _____ **Drug Screens.** I understand that in order to ensure that I am abstaining from all non-prescribed drugs, street drugs, or alcohol, I will be required to completed random drug screens.

18. _____ **Notification of Relapse.** I will notify my Provider immediately in the event that I relapse, or if I otherwise take any drugs that have not been prescribed to me including illegal drugs obtained from the "street". I recognize that my Provider understands that relapse may be part of the disease process, and that honest communication between myself and my Provider regarding a relapse is essential to my relationship with my Provider and treatment. Additionally, I recognize that it is essential that my Provider is aware of any relapse BEFORE a positive drug test is obtained. I understand that this is not a guarantee that I will not be discharged from the MAT Program for continued relapses to opiates or any other drugs of abuse that, I have in this agreement, or verbal agreement with my Provider been instructed not to use.

19. _____ **Counseling.** I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in all recommendations made by my Provider including counseling. I will provide written documentation of attendance of all meetings recommended to my Provider at each of my scheduled appointments. Counseling visits are required at minimum once monthly and failure to comply with this requirement may serve as grounds for my discharge from the MAT program.

20. _____ **Pharmacy of Choice.** I will fill all of my Suboxone prescriptions at the same pharmacy. **My pharmacy choice at this time is:**

Pharmacy Name: _____City: _____ State: _____

Phone: _____ Fax: _____

21. _____ **Contact Information.** I will provide the Clinic with my current contact information and will update that contact information immediately as necessary. I will notify the clinic immediately in the event that I change my address or phone number. I will be accessible to this clinic at all times in the event the clinic needs to contact me. **I understand that if the Clinic is unable to reach me within 24 hours, I may be discharged from the MAT Program.**

22. _____ **Pregnancy. (Women Only)** I am not pregnant and will not attempt to become pregnant without discussing this with my Provider. I will not have unprotected sex and will continue my birth control while I am taking Suboxone. I understand that if I become pregnant, I will be transitioned to buprenorphine. If I become pregnant, I will inform my Provider, so I can be treated in the safest way possible for me and my unborn baby.

23. _____ **Discharge from the Practice.** I understand that failure to comply with the requirements described above and/or any of the violations listed below may serve as grounds for my discharge from the MAT Program:

a. A failed drug screen without advising Provider of the lapse prior to the test.
b. Any attempt by me to alter, substitute, or tamper with a urine specimen obtained for a drug screen will result in my immediate discharge without recourse or appeal.
c. Failure to report for a required drug screen.
d. Distribution of Suboxone to any other individual will result in my immediate discharge without recourse or appeal.
e. Any alteration, tampering, forging, etc. of my Suboxone prescription will result in my immediate discharge from the program without recourse or appeal.
f. Failure to comply with prescribed use of my Suboxone.
g. Repeated requests to re-schedule appointments.
h. Not showing for scheduled appointment without calling ahead of time to let staff know that I will not be able to make it to my scheduled appointment, will result in my discharge without recourse or appeal.
i. Any illegal activity related to drug or alcohol use will result in my immediate discharge.
j. Any dangerous on inappropriate behavior that is disruptive to the clinic or to other patients (This includes reporting to the clinic or any other facility involved in my MAT treatment) will result in my discharge without recourse or appeal.
k. Any other breach of the terms of this contract.

Emergency Contact Information

Printed Name: _____Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

With my signature I give my consent for my medical information involving my MAT treatment to be discussed with my Emergency Contact listed above.

With my signature below, I attest that I have read and understand the above contract and that I have had the opportunity to ask questions and have them answered to my understanding. I also understand that violations of this contract may be grounds for my discharge from practice without recourse or appeal.

Patient Name: _____ DOB: _____

_____ _____ _____

Patient Signature (or Authorized Representative) Relationship to Patient Date/Time

Witness: As witness to this signature, I verify that the patient or authorized representative has read or had this form read to him/her, states the information is understood and has no further questions.

_____ _____ _____

Staff Member Name: Title: Date:

_____ _____

Physician Signature: Date/Time

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