Barrier Islands Psychiatry Opioid Treatment Contract

Patient Name: _____ Date: _____

As a participant in a mediation 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 of 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 doctors' office.

4. I agree to report my history and symptoms honestly to my doctor and the office staff. I will inform my doctor about any medications (prescription and non-prescription) that I am taking. I will report any changes in my medical history, such as becoming pregnant.

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 any recourse for appeal.

6. I understand that my medication must be stored safely, where it cannot be taken accidentally by children or pets, or stolen. If anyone else, including a child, takes my mediation, I will call 911 or Poison Control at 1-800-222-1222 immediately.

7. I agree not to deal drugs, steal, or conduct any illegal or disruptive activities in or around the doctor's office.

8. 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.

9. 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 mediation/prescription until the next scheduled visit.

10. I will be careful with my take-home prescription supplies of my medication. If I report that my supplies have been lost or stolen, my doctor may not provide me with a make-up supply.

11. I understand that at every visit, my doctor may ask me to bring my unused supply of medication for a medication count and that I many not get a refill if I do not bring my medication with me.

12. 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.

13. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

14. I understand that mixing this medication 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 directed or in higher than recommended therapeutic doses.)

15. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events.

16. I agree to take my medication as my doctor has instructed and not alter the way I take my medication without first consulting my doctor.

17. I understand that mediation 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.

18. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).

19. I agree to provide random urine samples and have my doctor test my blood alcohol level.

20. I understand that failure to maintain regular treatment while in this program will require me to incur Induction Fees again.

21. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature: _____ Date: _____