Alabama Clinics

PATIENT TREATMENT CONTRACT

Patient Name _____ **Date**_____

As a participant in buprenorphine 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 buprenorphine 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 that I will only purchase the medication in the state of Alabama.

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

11. I understand that mixing buprenorphine 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).

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 (excepting nicotine).

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

16. I understand that my insurance will not be filed, I won't get a bill to self-file, and that this will be a self-pay treatment basis only.

17. I understand that if I see a clinician, I will not be refunded for my visit and labs.

18. I understand that my visit(s) will not guarantee that I will be prescribed any medication.

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

_____ _____

Patient Signature **Date**

Suboxone Check List

- **I understand that my visit(s) will not guarantee that I will be prescribed any medication.**
- **I understand that if I see a clinician, I will not be refunded for my visit and/or labs.**
- Prescriptions are only to be filled in Alabama.
- Appointment must be kept as scheduled, appointments are at Doctor's discrepancy.
- Must be positive for prescribed medication, and negative for everything else.
- No pain meds taken from any Doctor, unless called and approved by one of our physicians.
- If positive for something other than your prescribed medications, you must pay an additional $200.00 for a Qualitative Drug Screen at any visit, upon Clinician's discretion.
- We can call you at any time to come in for pill count, you comply or will be dismissed.
- Drug screens can be witnessed, if you are caught using anything other than your own urine you will be dismissed.
- Payment has to be made before being seen, if using credit card in name other than your, that person has to be present, no payments taken over the phone.
- I understand that violations of the above may be grounds for termination of treatment.
- Signed and date Suboxone Contract.

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Patient Signature **Date**

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Clinic Employee