BUPRENORPHINE TREATMENT AGREEMENT

I, _____ as a participant in buprenorphine treatment at Link House Center for Behavioral Health & Addiction Treatment Services understand and voluntarily agree that (initial each after reviewing):

____ I will keep (and be on time for)all my scheduled appointments with the Nurse Practitioner and other members of my treatment team.

____ I will participate in group or individual counseling, 12-step recovery programs, or other types of treatment that I am asked to participate in.

____ I will keep the medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment.

____ I will take my medication as instructed and not change the way I take it without first talking to the Nurse Practitioner or another member of the treatment team.

____ I will tell the Nurse Practitioner or another member of the treatment team if I stop my treatment for any reason. I understand that I will need to plan ahead for any surgery or other medical procedures for which I may need medicine for pain.

____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

____ I will sign a release form to let the Nurse Practitioner speak to all other doctors, NPs, counselors that I see.

____ I will tell the Nurse Practitioner about all other medicines that I take, and let her know right away if I have a prescription for a new medicine.

____ I will use only one pharmacy to get all of my medicines:

Pharmacy name/location/phone #: _____

____ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Adderall, amphetamines) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

____ I will not use illegal drugs such as cocaine, marijuana, or amphetamines while taking buprenorphine. I understand that if I do, my treatment may be stopped.

____ I will not take any prescribed medication that can be addictive, such as benzodiazepines, stimulants, or opioid pain medicines, without the approval of the buprenorphine prescriber.

____ I will come in for drug testing and counting of my pills/strips within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drug use.

____ I will keep up to date with any bills from the office and tell the Nurse Practitioner or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

____ I understand that I may lose my right to treatment in this office if I breach any part of this contract.

Patient Signature: _____ Patient Name: _____

Provider Signature: _____ Provider Name: _____

Date: _____