Hope Alive Center

Buprenorphine Treatment Agreement

Patient Name: _____ **Date:** _____

As a participant in buprenorphine treatment for opioid addiction, I freely and voluntarily agree and understand this treatment agreement, in its entirety, as follows:

_____ 1. I agree that I have been informed that buprenorphine is a treatment designed to treat opioid addiction—not addiction to other classes of drugs. If I am actively addicted to other substances, I will need to be treated by other methods for those addictions.

_____ 2. I agree that medication management with buprenorphine is only one part of the treatment for my addiction and I agree to participate in a regular program of professional counseling while in treatment with buprenorphine.

Hope Alive Center will maintain compliance with the rules from the state of Tennessee Department of Mental Health and Substance Abuse Services, Division of Administrative and Regulatory Services for Nonresidential Office-Based Opiate Treatment Facilities. These new rules became effective as of January 12, 2017.

(Rule 0940-05-35-02)(e) "Counseling" or "Counseling Session" means a face-to-face individual therapeutic counseling session lasting not less than 20 minutes with a qualified provider or a group educational session lasting not less than 50 minutes. ***Attendance of a 12-step program such as Narcotics Anonymous shall not be considered counseling***. The Facility shall document each counseling session in a patient's medical chart.

(Rule 0940-05-35-09) Individualized Treatment Plan and Best Practices Utilized (b)(c) A patient in the maintenance phase of treatment shall: Have a scheduled office visit at least every 2 to 4 weeks and receive counseling sessions at least monthly.

_____ 3. I agree to abstain from ***all*** illegal drugs, alcohol, and other addictive substances while in treatment with buprenorphine.

_____ 4. I agree that I will be subject to drugs screens.

_____ 5. I agree to keep and be on time for all my scheduled appointments.

_____ 6. I agree to immediately notify the office of any change of address and/or phone number. All patients must be accessible to this office at any time when this office needs to contact them.

_____ 7. Voice mail must be set up. If this office cannot reach the Patient within two hours, this office has the right to discharge the Patient without further notice.

_____ 8. I agree that a network of support and communication is an important part of recovery. I maybe asked to signed a Release of Information authorization to allow contact, as appropriate, between my doctor and/or his staff and outside parties, including physicians, therapists, probation/parole officers, and other parties. Contact will only be made when the doctor has determined that communication is necessary for effective treatment and recovery.

_____ 9. I agree to adhere to the payment policy outlined by this office.

_____ 10. I agree to store my medication(s) safely where it cannot be taken accidentally by children or stolen by others. I further agree that if my buprenorphine is ingested by anyone beside me, I will call 911 or the Poison Control Center at (800) 222-1222 or TN Poison Control Center 615-936-0760.

_____ 11. I agree not to sell, share, or give any of my medication(s) to another person. I understand that such mishandling is a serious violation of this contract and will result in my treatment being terminated without any recourse for appeal.

_____ 12. Medication lost, stolen, or damaged ***will not*** be replaced. It is my responsibility to protect my medication. I understand that the consequence of not protecting the medication is that I may be without prescribed medication for a period of time.

_____ 13. I agree that if my doctor recommends that my medication(s) should be kept in the care of a responsible member of my family or another person, I will abide by such recommendation.

_____ 14. I agree not to conduct any illegal or disruptive activities in or around the doctor's office and/or pharmacy and to treat all office staff with respect. This includes excessive calls, texts or voice mails which would be considered harassment. I understand that should such behavior occur, I will be terminated from treatment without recourse for appeal and the appropriate authorities will be notified (if necessary).

_____ 15. I agree that my medication/prescription can only be given to me at my regularly scheduled office visits. No medications will be called into any pharmacy.

_____ 16. I agree to inform the doctor of all medications/supplements/vitamins prescribed by other doctors, pharmacies, or other sources.

_____ 17. I agree that I have been informed that it **can be dangerous to mix buprenorphine with alcohol or other sedative drugs such as Valium, Ativan, Xanax, Klonopin, or any other benzodiazepine drug –so dangerous that it can result in accidental overdose, over-sedation, coma, or death.**

_____ 18. I agree to take my medication(s) as the doctor has instructed. I understand that only the doctor can change the way I take my medication(s).

_____ 19. I agree that I should not drive a motor vehicle or operate heavy or dangerous machinery during my first two weeks of treatment to ensure that I can tolerate my medications without becoming sleepy or clumsy as a side-effect.

_____ 20. I agree that I will be open and honest with my doctor and the treatment team about my addiction and overall health history and will inform my doctor and therapist about cravings or unhealthy situations in which I am involved, specifically about any relapse that has occurred *before* a drug test confirms it.

_____ 21. I understand that I may be witnessed by a staff member when giving urine samples. I also understand that attempts to alter my urine or bring in urine from others will result in termination from treatment without recourse for appeal.

_____ 22. I understand that I must arrange for childcare, since children cannot be left unattended and may distract from the therapeutic environment.

By signing below I attest that I have read and understand the above agreement and that I have had the opportunity to ask questions and have them answered to my understanding. I also understand that violations of this agreement may be grounds for termination of treatment without recourse for appeal.

Patient name (print clearly)

Patient signature Date

Witness signature (Hope Alive Center employee) Date