Hope Alive Center

Vivitrol (Naltrexone) Treatment Agreement

Patient Name: _____ **Date:** _____

As a participant in Vivitrol (naltrexone) treatment for opioid/alcohol 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 Vivitrol (naltrexone) is a treatment designed to treat opioid/alcohol 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 Vivitrol (naltrexone) 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 Vivitrol (naltrexone).

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

_____ 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 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. I understand that

should such behavior occur, I will be terminated from treatment without recourse for appeal and the appropriate authorities will be notified.

_____ 11. I agree that my medication/prescription can only be given to me at my regularly scheduled office visits.

_____ 12. I agree to inform the doctor of all medications/supplements/vitamins prescribed by other doctors, pharmacies, or other sources.

_____ 13. 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.

_____ 14. 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.

_____ 15. I understand that a staff member when giving urine samples may witness me. 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.

_____ 16. 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)

Patient signature Date

Witness signature (Hope Alive Center employee) Date