

PATIENT TREATMENT CONTRACT

Patient Name _____ Date _____

As a participant in buprenorphine treatment for opioid 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 and telephone consultations.
2. I agree to adhere to the payment policy outlined by this office. All fees are due prior to the start of treatment and are non-refundable once treatment has begun.
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 not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. 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).
11. 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.
12. 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.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.
16. I understand that this is a 7 week detoxification program, any treatment rendered after my follow-up appointment on week 8 will be subject to additional fees for services rendered.
17. By signing below I acknowledge that I have been informed of the protocol and regulations as set forth by Jersey Shore Daytox for opiate dependence detoxification and give my consent for treatment.

_____ Date _____

_____ Date _____

Patient Signature

Witness Signature